CIVIL DISTRICT COURT FOR THE PARIS OF ORLEANS
STATE OF LOUISIANA
DIVISION K
NO. 96-8461, DOCKET NO. 4
CLASS ACTION CLAIM

GLORIA SCOTT and DEANIA JACKSON,

Plaintiffs,

v.

THE AMERICAN TOBACCO COMPANY, INC., et al.,

Defendants.

Videotaped Deposition of:
ALDEN G. COCKBURN, M.D.

TRANSCRIPT of testimony as taken by and before Cynthia L. Varney, a Shorthand Reporter and Notary Public of the State of Florida, at the Crowne Plaza Hotel, 700 North West Shore Boulevard, Tampa, Florida, on Thursday, October 26, 2000, commencing at 9:15 in the morning.

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EXHIBITS

ALDEN G. COCKBURN, M. D.,
4700 North Habana Avenue
Tampa, Florida, sworn.

DIRECT EXAMINATION BY MR. LEGER:

Q. Doctor, my name is Walter Leger, and I'm, as you know, an attorney representing the plaintiffs in a case in New Orleans in which you've been retained as an expert witness. I know and understand that you've given your deposition several times before, and therefore I'm assuming you kind of understand what's going on --

A. I do.

Q. -- in the way of procedure and otherwise. I'm going to ask you a series of questions over several hours, and if you don't understand my question, if there's any misunderstanding, please let me know. If we're talking over each other or otherwise, let me know, too, and -- because I assume we're going to have a tendency to communicate at one point, and as you know, the court reporter has got to be able to hear us individually, and separate and apart from each other.

I'm going to ask you, now, to state your name and your office address, once again, for

the record.

A. Alden George Cockburn, M.D., 4700 North Habana Avenue, Tampa, Florida 33614.

Q. And, Doctor, would you -- you have been deposed before, I understand --

A. I have.

Q. -- correct? About how many times?

A. Over 15 times.

Q. Okay. Now, have you been deposed in any other tobacco-related case, other than the Engles case?

A. No, I haven't.

Q. Have you, in connection with tobacco or cigarette litigation, been retained or consulted in any other matter, other than the Engles case?

A. None.

Q. So your only association with cigarette tobacco companies has been your involvement as an expert witness on behalf of tobacco companies in the Engles case and now this case --

A. That's correct.

Q. -- is that correct?

MR. WATTLEWORTH: Object to the form.

MR. LEGER: What's objectionable about the form?
MR. WATTLEWORTH: Association with the cigarette and tobacco companies.
BY MR. LEGER:
Q. Do you not --
MR. WATTLEWORTH: He's --
BY MR. LEGER:
Q. Are you not here on behalf of tobacco companies as an expert witness?
A. Yes, but not associated with them.
Q. Do you have trouble, you know -- does it bother you to be suggested that you're associated with the tobacco companies?
A. Not particularly, no.
Q. All right. Is there something about the word "associated" that bothers us? I'm just trying to get the --
MR. WATTLEWORTH: Well, it's misleading, I mean, association with the tobacco companies. It's unclear what you mean by "associated with tobacco companies." I think his response has clarified that, though.
BY MR. LEGER:
Q. Okay. I mean, you're paid to be

here by --
A. That's correct.
Q. -- a tobacco company; right?
A. That's correct.
Q. Is it only one company that's paying you or is it all of them?
A. Just one that I know of.
Q. Which company are you getting a check from?
A. R.J. Reynolds.
Q. Okay. You think that means you're not associated with them, the fact that you're not getting money from them?
MR. WATTLEWORTH: Object to the form.
MR. LEGER: Okay. What's objectionable about the form?
MR. WATTLEWORTH: Well, it's argumentative.
MR. LEGER: Okay.
BY MR. LEGER:
Q. You can answer the question.
A. I have a financial relationship with R.J. Reynolds as an expert witness.
Q. Okay. Now, in connection with the

15 or so other cases that you've testified in previously, can you give me an idea of what those cases involved?
A. Usually, independent medical evaluations or an expert witness in a malpractice litigation.
Q. Now -- and I have read your previous deposition, and I really don't want to go over that area in detail, but I just want to make sure that there's nothing missing from that deposition, and the deposition I'm talking about is the deposition you gave in the Engles case; correct?
A. Correct.
Q. Have you reviewed that deposition recently?
A. No, I haven't.
Q. Have you looked at it at any time since your testimony in the Engle trial?
A. No, I haven't.
Q. You haven't looked at it in anticipation of testifying in this deposition today?
A. No, I haven't.
Q. In that deposition, I understand that you had testified in approximately 10

malpractice cases, either by deposition or otherwise?
A. Yes.
Q. Okay. And three malpractice cases were cases involving claims against you; is that correct?
A. That's correct.
Q. The other seven were as an expert witness on either -- behalf of either the plaintiff or the defendant; correct?
A. That's correct.
Q. In most cases, you've been retained and testified in connection with the defense of a doctor accused of malpractice --
A. That's correct.
Q. -- correct? How many of those were plaintiff?
A. That is that the doctor was not the plaintiff?
Q. That's correct, where the doctor was not the plaintiff.
A. About three.
Q. And did you testify in any where the doctor was the plaintiff? -- I mean the party suing the other party.

A. Yes.
Q. Okay. And what case was that, where the doctor sued someone else?
A. I'm sorry. I'm confused by the legalese.
Q. The term. That's what I was -- that's -- right.
A. No, I haven't --
Q. Okay.
A. -- where a doctor sued someone else, no.
Q. All right. Your testimony has been on behalf of doctors --
A. That's correct.
Q. -- when being sued, generally?
A. That's correct.
Q. Otherwise, in a -- I'm sorry. Was it three cases you testified for the person suing the doctor?
A. That's correct.
Q. Have -- since the Engle deposition, have you testified in or have you been retained or involved in any malpractice cases?
A. No.
Q. Since your Engles deposition, have

you been involved in any cases whatsoever --
A. No.
Q. -- other than this one?
A. None.
Q. So may I assume that your testimony in the Engles deposition regarding your prior cases and prior -- and history of testifying is complete, basically --
A. That's correct.
Q. -- other than this case and other than testifying at the Engle trial; right?
A. That's correct.
Q. After your deposition in the Engles case, did you go back and try to identify who the patients were that sued you? In other words, apparently, in Engles, you didn't remember the names of two of the three patients that sued you.
A. Did I go back and --
Q. Yes, sir.
A. Which ones are you concerned about?
Q. Well, all three of them, actually. The first one, 1990 or so?
A. I can certainly get you that information. I don't keep it on the top of my head.

Q. Okay. I appreciate that, and I would like that information, but my question is, after the deposition, at the -- either on your own or at the request of lawyers of tobacco companies, did you do any inquiry into that case?
A. No, and I don't know why I would.
Q. Okay. That's what I'm wondering, if they asked you to give them information about that case.
A. No.
Q. Okay. Do you remember who the -- the names of the lawyers that sued you?
A. No.
MR. LEGER: Off the record.
(Discussion off the record.)
BY MR. LEGER:
Q. By the way, did you bring a file with you today?
A. No, I didn't bring anything.
Q. No? Okay.
MR. LEGER: Do you have the subpoena, Christine?
MS. DESUE: Mm-hmm.
MR. LEGER: Do you have an extra copy?

BY MR. LEGER:
Q. Have you been shown a copy of this notice of deposition with Exhibit A attached?
A. Yes. Yes, I have.
Q. When did you get that?
A. I saw a copy of this yesterday.
Q. Did you see it before then?
A. No.
Q. Okay. So at no time -- at no time did you attempt to gather information in connection with this particular document that I just showed you; correct?
MR. WATTLEWORTH: Well --
A. Let me read the document over. I didn't --
MR. WATTLEWORTH: -- for the record, you know, we have -- he has gathered information. We've produced some of that to you already.
MR. LEGER: Okay. Well, that's the problem, some of it.
MR. WATTLEWORTH: I'm certain you're going to tell us in a minute here. Yeah, right. I'm sure you're going to let us know which information that is.
MR. LEGER: Do you have exhibit

tags? Because I would like to mark the document that the doctor is reviewing now, which is a notice of deposition with Exhibit A, which, under the rules of the case management order and the ruling of the Special Master are deemed as if submitted as a subpoena duces tecum. We're going to call that Cockburn No. 1.

THE DEPONENT: "Co-burn."

MR. LEGER: I'm sorry.

THE DEPONENT: Spelled "Cock-burn"; it's pronounced "Co-burn."

MR. LEGER: Cockburn No. 1.

MR. WATTLEWORTH: So this is 1, not A?

MR. LEGER: Yeah, that's right, the number 1.

BY MR. LEGER:

Q. Now, Doctor, you just looked through this document. Have you provided everything that's requested in this document No. 1?

A. Yes, I have.

Q. Okay. And who did you provide those things to?

A. Mr. Wattleworth.

Q. Okay. We're going to go through

this. Have you provided a -- back in June, you issued a report, correct?

A. I did.

Q. And at that time, you provided the lawyers for the tobacco companies with a curriculum vitae; correct?

A. I did.

Q. Is there an updated version of that curriculum vitae?

A. There is no updated version. I realize that there -- it is a little dated, but nothing substantially new has occurred since that was written.

Q. So, by "dated," you mean that the curriculum vitae, even in June, was a little out of date; is that correct?

A. It's a little out of date, yes.

Q. So there's just a little more information --

A. No. Actually, I would delete the information on the last page. Those manuscripts that were in preparation are -- I guess you could consider them defunct. They didn't proceed to publication.

Q. Okay. On the fourth page, the

manuscript regarding a 25-year experience with seminoma and regarding spermatocytic seminoma -- seminoma; correct?

A. Correct.

Q. You would delete the -- they are no longer in preparation?

A. Correct.

Q. How long ago were they in preparation?

A. Oh, I was still pursuing them up until about 1989, 1990.

Q. Okay. So by 1990, there were no longer any manuscripts in preparation?

A. That's correct.

Q. Okay. And we're going to -- just for the sake of the record, we're going to attach a copy of that as -- that curriculum vitae -- as Cockburn No. 2, and then we're going to talk about that in a little bit.

You also provided what is called a reliance list; is that correct, Doctor?

A. That's correct.

Q. And now we're talking about provided that in June?

A. That's correct.

Q. May I show you this reliance list, Doctor? And what was this document, which we're going to mark as Cockburn No. 3?

A. That's the bibliography used in making the report.

Q. Have you acquired any further information or materials since that date which you consider will be relied upon or important to your opinions in this case since this was submitted in June of --

A. No.

Q. -- 2000? So your entire opinions are based on what's in this material; correct?

A. Well, I have a fund of knowledge that I bring to the subject that is well beyond that which is annotated in the bibliography, yes.

Q. Now, just for the sake of clarification, we appear to have been provided -- and it's really, honestly difficult to determine, but -- a few additional medical journal articles that are not on this list, I believe we were provided by counsel for the tobacco companies.

A. Okay.

Q. So did they get that from you, something supplemental to this?

A. Well --
MR. WATTLEWORTH: If you -- perhaps if he's -- I'm sorry. I'm just saying, if you have those articles that you could identify to him, that might assist in determining exactly how he came about acquiring them.
BY MR. LEGER:
Q. I'm going to show you your article regarding BTA Quantitative Assay by Casetta, and a urinary -- another one, a urinary BTA Stat and other things, by Serretta, et al.
A. Mm-hmm.
Q. These are things that you have reviewed since giving your opinion?
A. I wouldn't say since giving my opinion. I probably read these along at the same time that I prepared that. I just didn't include them as part of the bibliography.
Q. Okay. Where did you get those articles? In other words, did you go look them up or were they given to you by tobacco company lawyers?
A. I think these were given to me.
Q. Do you know who gave them to you?
A. Mr. Wattleworth.

Q. Okay. And how about -- I'm also going to show you an article by Welch, et al., from Journal of the American Medical Association, Are Increasing Five-Year Survival Rates Evidence of Success Against Cancer?
MR. WATTLEWORTH: Let's go off the record for a second.
(Discussion off the record.)
MR. LEGER: And let's just clarify that on the record.
MR. WATTLEWORTH: Sure, yeah.
BY MR. LEGER:
Q. As I appreciated, the JAMA article that you just looked at by Welch is not an article that you have reviewed in formulating your opinions; is that correct?
A. Or I've seen before; that's correct.
Q. It was never provided to you by anybody but me at this deposition?
A. That's correct.
Q. Okay. And apparently it was mistakenly provided to us, suggesting that you relied upon it; correct?
A. That's correct.
Q. All right. The other two, however,

were provided to you by lawyers for the tobacco company?
A. That's correct.
Q. Okay.
MR. WATTLEWORTH: And those being -- what? -- the Casetta article and --
MR. LEGER: Casetta and Serretta articles, et al.
MS. DESUE: And there's two --
BY MR. LEGER:
Q. And there are two additional articles, one Comparative Sensitivity of Various Tests, Including NMP-22, by Marta Sanchez-Carbayo, and a Comparative Evaluation of Various Tests, Including NMP-22, by Giannopoulos, et al. Those are not on your reliance list, and I'm wondering if you have also seen those and were they also provided to you by lawyers for the tobacco companies or a lawyer for the tobacco companies?
A. I read this article in the Journal, and I don't remember -- I honestly don't remember where -- if I saw this one outside of the Journal and --
Q. Which one are you referring to?
A. This one in the Journal of Urology,

Comparative Sensitivity by Marta Sanchez-Carbayo. This one from Adult Urology, the Comparative Evaluation of the BTA Stat Test, I think I read this one, and this was provided by the tobacco company.
Q. Okay. Now, you say you may have -- did you make copies, though, and send these as if to be provided to us?
A. I didn't make --
Q. Okay.
A. -- copies, no.
MR. LEGER: And we don't need to even identify them, unless you would prefer us to.
MR. WATTLEWORTH: No.
MR. LEGER: I'm just trying to get --
MR. WATTLEWORTH: I think, since we've identified the authors --
MR. LEGER: Yeah.
MR. WATTLEWORTH: -- we have an idea of what we're talking about.
BY MR. LEGER:
Q. Now, in connection with the articles that we just spoke about, the four articles we spoke about that are not listed in here, you saw

those articles after -- after your opinions were given in this report?
A. Possibly, yes.
Q. Did they materially affect your opinion in any way?
A. No.
Q. Change it, modify it, otherwise?
A. No. It's just additional data.
MR. LEGER: Chris, I think I've numbered these right.
MS. DESUE: Yes.
BY MR. LEGER:
Q. Now, other than the articles that we've talked about and the articles on Cockburn No. 3, the 16 or so documents and articles, are there any other materials, documents, writings, databases, otherwise, that you relied on in formulating opinions, other than general -- the general body of --
A. No.
Q. -- of knowledge?
A. Other than the general body of knowledge that's available, no.
Q. Did you particularly rely upon, perhaps, any treatises or textbooks in

A. None that I'd specifically want to mention, no.
Q. Okay. And you consider that Campbell's Urology, that textbook, is authoritative?
A. I do.
Q. Is it a textbook which you rely upon regularly in the context of your practice?
A. I do, as a reference.
Q. Are there any other references that you consider important in your ordinary practice?
A. Other than the journals, no.
Q. Which journals do you consider important?
A. Urology, Journal of Urology, Investigative Urology, Contemporary Urology.
Q. Are there any particular journals that you consider important and reliable in the context of oncology?
A. Yes; Cancer, CA, the cancer journal put out by the ACS, Oncology News.
Q. Do you prescribe -- I'm sorry -- subscribe to any of these publications?
A. I do.
Q. Do you subscribe to all of them,

particular -- in particular language in treatises and textbooks in formulating those opinions?
A. No.
Q. Are there any particular --
MR. WATTLEWORTH: I've got a question. Are you talking about outside of what's listed on his reliance list?
MR. LEGER: Outside of what's listed on his --
MR. WATTLEWORTH: Okay.
MR. LEGER: -- on the reliance.
MR. WATTLEWORTH: Because Campbell's Urology is listed on there.
MR. LEGER: Yes, mm-hmm.
THE DEPONENT: Well, that's -- no. Outside of that, no.
BY MR. LEGER:
Q. And there are a number of other tests in -- texts in urology and in uro-oncology, I assume; correct?
A. That's correct.
Q. Are there any particular texts, other than Campbell's Urology, that you consider authoritative in the context of what we're talking about in this case?

basically, that you just listed?
A. No. I subscribe to Urology, Contemporary Urology. The others I read in -- either on the Internet or the library.
Q. So you do not subscribe to any of the cancer journals?
A. No, I don't.
Q. Or oncology materials; correct?
A. Correct.
Q. Have you been provided with copies of any medical records pertaining to Gloria Scott and Deania Jackson?
A. No, I haven't.
Q. Do you expect to be provided any such records?
A. No.
Q. Have you asked for records?
A. No.
Q. Do you know who Gloria Scott and Deania Jackson are?
A. No, I don't.
Q. Do you -- this subpoena requested your billing records. Have you provided a copy of those billing records?
A. I don't think I have, because I just

submitted a bill maybe a month ago.
Q. Do you remember what that bill was for, in terms of how much?
A. About $3,000.
Q. And how much are you charging in this case?
A. I think it's on the report, $300 for a deposition, or 350, something like that.
Q. Okay. If I told you were -- you said you were charging 350 for consultation and $500 for a deposition, would that surprise you?
A. No, but it would sound better.
Q. Doctor, in the Engles case, you testified that you were charging $250 an hour --
A. Uh-huh.
Q. -- is that correct?
A. Yes. Inflation has been going up.
Q. So do you consider that it's a result of inflation that you've increased your fees or are you more expert now?
A. I've increased my fees not because I'm more expert, just because of the hassle factor, maybe.
Q. Explain the hassle factor, sir.
A. Just it's not medicine. It's not

what I'm used to. It's not what I like. It's not pleasant.
Q. Why did you agree to do it?
A. Partly because I think that, as I was in the Engle case, I feel strongly about one's need to accept responsibility for one's actions and -- instead of blaming outside forces, like addiction and things like that, for things that we do.
Q. What does that have to do with your testimony as an expert urologist?
A. Well, in this case, as was presented for screening for bladder cancer, I disagreed with the proposal as it was and I didn't think that that was good medicine, and that's the main reason.
Q. Do you have an idea of better medicine?
A. I think so.
Q. Okay. What is that?
A. I think that it involves a screening method that is based on a routine examination that we all do, and that is a urinalysis, and that it should be followed by the same normative practices that we do for anyone with an abnormal urinalysis; and I don't think that we specifically have to name

something as was named here, the NMP-22, as the specific test of choice for an evaluation that has already been established as a -- the normative way of approaching someone with blood in the urine.
Q. Okay. Explain that. You object to the monitoring program?
A. Oh, no. No, not at all do I disagree with the monitoring program. I think we have to have a monitoring program. I disagree with the form.
Q. Okay. Let's talk about that. You agree, it is your opinion that a monitoring program to attempt to detect bladder cancer at an early stage is good, sound medicine and science --
A. Absolutely.
Q. -- correct? Where we -- where you disagree is the particular methodology of the program proposed --
A. That's correct.
Q. -- by the scholars and doctors and professors in the state of Louisiana?
A. That's correct.
Q. Okay. Can you explain to me particularly what it is you disagree with?
A. The form, as I see it, implies that

individuals who -- as I understand it, who have been exposed to tobacco smoke by smoking themselves are therefore susceptible to developing bladder cancer, and therefore, as I understand it, all of those individuals deemed potentially vulnerable ought to be evaluated by the methods that were described; and I take issue with only one of those tests.
Q. Which test?
A. The NMP-22.
Q. Okay. So do I understand, then -- and I'm really just trying to establish our points of agreement so we can talk about what we disagree on. Do I understand that you agree that persons who are exposed to tobacco smoke by smoking should be monitored for bladder cancer?
A. As anyone over the age of 50 should be, yes.
Q. Well, do you -- let me see if I can make sure we understand each other. Is it your testimony that everyone, whether they smoke or not, should be monitored for bladder cancer?
A. It depends on what you mean by "monitored." We monitor individuals when they present to us for a physical examination by looking

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at their urine. Is that cancer detection or is that monitoring?
Q. Okay. Let's factor out a physical examination because -- let's talk about the physical examination aspect. There is no organized program that allows for funding of regular physical examinations; is that correct -- in America?
A. No, that's correct.
Q. No, there is no program?
A. That's correct; there is no program.
Q. Is there a program for monitoring for individuals in the population with no particular risk factors in the state of Florida?
A. When you say "a program," that means sponsored by --
Q. Someone paying for it.
A. No.
Q. Are you aware of such a program in the state of Louisiana?
A. No.
Q. Is there a recommendation by any medical associations or health care organizations for such program?
A. I don't know of one.
Q. Okay. I mean, in Florida or

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Louisiana or in the United States of America, you're not aware of any; correct?
A. No, I'm not.
Q. Or in any other country in the world; is that correct? -- You're not aware. There may be, but you're not aware; correct?
A. There may be, but I'm not aware.
Q. Okay. Now, so generally what you suggest is that, however, if a person is seen in a doctor's office for an examination on an ordinary basis, one of the things that they should be tested for is urinalysis -- or a urinalysis should be done?
A. That depends on how general and specific you want to make the word "examination." If they're coming in for an annual examination, yes, I think that should be. If they're coming up for a follow-up on their heart medicine, no.
Q. The fact of the matter is, though, Doctor -- and I don't really mean to quibble with you, though, but -- in the context of the health care system in the United States of America, it is not ordinary for Americans to simply come in annually for a, quote, physical examination; isn't that true?

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MR. WATTLEWORTH: Object to the form.
A. We advocate it.
BY MR. LEGER:
Q. Who is "we"?
A. The medical community advocates that everyone over the age of 50 should be seen by a doctor on an annual basis.
Q. Okay. Where do you advocate it and how do you advocate it?
A. Daily to my patients.
Q. To your --
A. It's not done through -- I don't know of the American Medical Association having a policy like this or that has been advertised as such, but it is certainly practiced on a daily basis, I think, by most physicians, who recommend that over a certain age, individuals should be examined at least once a year.
Q. What we know is, though, that it is a clear, minuscule minority of people in America that do go in for annual physicals; isn't that true?
MR. WATTLEWORTH: Object to form.
A. We don't have a national health

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system.
BY MR. LEGER:
Q. Exactly. But, I mean, the point is, Doctor, that -- I mean, you would agree, though, that a very small minority of people in America do go in for annual physicals; isn't that right?
MR. WATTLEWORTH: Object to the form.
A. I don't know -- I don't know that I would say a small minority.
BY MR. LEGER:
Q. Would you say a medium minority?
MR. WATTLEWORTH: Object to the form. What do you mean by "medium minority"?
MR. LEGER: I don't know. That's what I'm trying to find out, what he knows.
BY MR. LEGER:
Q. Is -- the next one is a large minority? I --
A. It depends on population groups, income strata, all of those. Most people don't go to a doctor unless they have a complaint.
Q. Exactly.
A. Yes.
Q. And, Doctor, there are, however,

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some companies that will pay for annual physicals by employees; correct?
A. That's correct.
Q. There are some programs that allow for payment of annual physicals; correct?
A. That's correct.
Q. The -- if an individual walks in off the street to a doctor's office, under the current American health care system, and says, I want a physical examination, will most insurance companies pay for the physical examination?
A. Yes.
Q. Even with no symptoms, no symptomology?
A. That's correct.
Q. Okay. When a person comes into a family practitioner's office for a physical examination, what does the doctor do, ordinarily?
A. An asymptomatic individual comes into the doctor and says, I'd like to have a physical exam?
Q. Mm-hmm.
A. I think he gets a physical examination; he gets a urinalysis; most likely, he'll get some blood work -- a CBC, a basic

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metabolic profile -- and then, depending, he may get an EKG; and depending on his age or her age, they may have a colonoscopy.
Q. So does he get a cystoscomy (sic)?
A. Cystoscopy?
Q. Cystoscopy.
A. No, unless indicated by blood in the urine.
Q. And it's your testimony that insurance companies will pay for all of those tests without evidence of symptom?
MR. WATTLEWORTH: Object to the form.
A. I honestly don't know. My impression is that they do, simply because I see a fair number of patients who do come in annually with no complaints, just for a checkup, and I haven't heard any complaints from them that the insurance company did not pay for it or would not pay for it or that they were afraid that the insurance company would not pay for it.
BY MR. LEGER:
Q. Okay. So the fact of the matter is that you don't know whether, in the case of your patients who come in for an annual physical --

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whether they're paying for it themselves or whether their insurance companies are paying for it?
A. I do know. I know that most of them do pay a co-payment but that the insurance company pays for the procedure.
Q. Okay. Now, do you know, in the case of those patients that come in for annual physicals, whether they're part of a particular employer group program or otherwise?
A. No. I think that most of them do not have a -- the program you describe.
Q. Okay. Now, let's get back to this particular program. You believe that, in connection with a physical examination, it is entirely appropriate and proper and medically sound to perform a urinalysis even in a person who has no particular known risk to bladder cancer; correct?
A. Absolutely.
Q. Okay. And what are you looking for in a urinalysis?
A. What do you look for in a urinalysis?
Q. Yes, sir.
A. Glucose, ketones, bilirubin, blood, leukocytes, nitrite, protein.

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Q. And what are you looking for in the context of attempting to determine bladder cancer?
A. Blood or protein.
Q. Now, with respect to further analysis -- and you're talking about in the context of what you think is normal, a group with no risk -- now assume you do a urinalysis and you find blood work which is suggestive of possible bladder cancer; correct?
A. Not blood work; you find blood in the urine.
Q. You find hematuria.
A. Correct.
Q. You find blood in the urine. And then blood in the urine suggests what to you?
A. Suggests an abnormality that needs to be evaluated.
Q. Okay.
A. It's a red flag.
Q. So now you have taken a population of people who have no particular high risk for any particular disease -- and we're talking theoretically -- and now, however, once you find hematuria, or blood in the urine, they are at high risk for something --

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A. That's correct.
Q. – correct? And you would suggest that they were – and I'm not – I'm leading you, really, to try to get to the point. You would agree, though, then, that they are high risk for a number of abnormalities, including bladder cancer –
A. That's correct.
Q. – correct? And what are those potential problems that hematuria is suggestive of?
A. Across the board, male and female, it would be stones in the collecting system, some congenital abnormality, infection, and then bladder cancer, and then for men, in particular, benign prostatic hypertrophy.
Q. What is benign prostatic hypertrophy?
A. It's something that you and I have and will get worse from as time goes on because the prostate grows in response to trophic stimulation from the testosterone, the male hormone.
Q. Okay. So at that point before you do the urinalysis, and in the context of bladder cancer, the general population is certainly, obviously, not at any particular high risk for

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bladder cancer, correct?
A. That's correct.
Q. All right. Now, once you have determined that there's hematuria, the general – that population – or that person who has hematuria is now determined to be at high risk for stones, congenital abnormalities, infection, bladder cancer, benign prostatic –
A. Hypertrophy.
Q. – hypertrophy?
A. Not high risk, but high suspicion.
Q. Okay. And the next step is what?
A. We follow an algorithm to evaluate the entire urinary tract. We do an IVP, an intravenous pyelogram, to delineate the upper collecting system and the ureter; and then we look into the bladder cystoscopically with a cystoscope, and then that gives direct visualization of the bladder, the prostate, and the urethra. We obtain a urine specimen for cytologic evaluation, and we send off a urine culture.
Now, we're exploring the use of various tumor markers that have been identified through molecular biological techniques, and among which are the NMP-22 and the BTA and the Telomerase

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and the cytokines, etc.
Q. The things mentioned in your report, the –
A. That's correct.
Q. – FDP, the vascular endothelial growth factor, you're looking for molecular prognostic markers in P 53 gene, etc.; correct?
A. That's correct.
Q. Ordinarily, would you run all of those tests?
A. No, no, not at all. Most of those are investigate – investigative – are in the process of being investigated. They are used in major teaching institutions, really, at this point – not – when I say "used," they're being evaluated. No one really is using them in a clinical basis because their reliability is certainly in question, and that's what this is all about.
Q. Okay. That's where we're trying to get to. Your step, after seeing hematuria, would be, rather than running – in a typical clinical setting – would be, rather than running an NMP-22 or a BTA Stat or an FDP or Telomerase assay or otherwise, would be cystoscope; right?

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A. Cystoscope, absolutely.
Q. And you would also have cytology performed on the –
A. On every one of them.
Q. – urine sample?
A. And I want to add, I would also – if I had them available to me, I would use these other tests, as I am presently using the BTA. Okay? The problem is the expense of these tests and whether or not the insurance company will pay for them.
Q. All right. So you say you would use them because you believe – and you've looked at the articles – you believe that they have reached sufficient scientific acceptability?
MR. WATTLEWORTH: Object to the form.
BY MR. LEGER:
Q. Correct?
A. I think that they have reached – certainly, they've reached – as far as the NMP-22 – have reached regulatory acceptability by the FDA, so they have approved it for that.
Again, the problem comes down to utility and cost, and it is used adjunctively with

the other established methods.
Q. Mm-hmm.
A. So the BTA and the NMP-22 are used but, again, as an adjunct to these others.
Q. And I guess that's my question. Do you have any objection to the use of BTA Stat as a diagnostic tool?
A. I do.
Q. Okay. What is that?
A. A high failure rate, both in terms of false positives in patients with hematuria and false negatives in those patients who have fairly well differentiated low grade tumors.
Q. Do you think BTA Stat, in your mind, is insufficiently specific in low grade tumor?
A. It's sensitive for low grade tumor.
Q. It is sensitive?
A. In -- not sufficiently sensitive for low grade tumors.
Q. But is -- has been -- but is sufficiently sensitive in invasive tumors --
A. Yes.
Q. -- correct? Okay. What about NMP-22 regarding low grade tumor?
A. A little better than BTA, but it's

sometimes not as good as regular urine cytology.
Q. Okay. And what about in invasive tumor?
A. Invasive tumor, they -- it tends to track well, with a higher specificity and sensitivity, and in that case, better than urine cytology.
Q. Now, you note that the plan recommended by the doctors in Louisiana calls for both NMP-22 and cytology; correct?
A. That's correct.
Q. Do you have an opinion as to the usefulness of those two items together?
A. Oh, I think that they're -- they are additive and synergistic.
Q. So basically, would you agree that they effectively complement each other?
A. They do.
Q. They fill the weakness of each other; correct?
MR. WATTLEWORTH: Object to the form.
BY MR. LEGER:
Q. Is that your opinion?
A. Yeah, for a price.

Q. What is the price?
A. I don't know what, specifically, the price is for the NMP-22. I know for urine cytology ranges anywhere from about $120 to up to $300, depending on what you get with your study and who -- what company does it.
Q. Okay. How much does a -- strike that.
What would be a reasonable price? What would be a price that would make it worthwhile to you to use it?
A. Something that the government and the insurance companies would pay for.
Q. Okay. Under $100 for cytology?
A. Well, you know, it's nice to throw out a figure, but it's a matter of preparation. The cytologist has to see it, and then it has to be reviewed by a cytopathologist, so there are a lot of steps in there, and that's what adds the cost into it.
Q. Now, a cytologist is a technician, basically; correct?
A. Yes.
Q. And a --
A. A highly skilled technician.

Q. And a cytopathologist, is that a doctor --
A. Yes.
Q. -- medical doctor?
Okay. Doctor, I want you to take the cost factor out now.
A. Mm-hmm.
Q. Assume, hypothetically, that cost is not a factor. Would you agree that the two of these tests, used together, are effective and would be recommended for attempting to monitor for bladder cancer?
A. In what individuals?
Q. In an individual in whom hematuria is found.
A. Oh, yes. Yes, I think there's a clear role for both of those there, or some tests as good or better than the NMP, yes. The reason we have the NMP is because of the failings of the cytology, so if we find something that's better than, across the board, we're going to use it.
Q. Are the other tests that you talk about -- BTA Stat, FDP, Telomerase assay, and others -- are those complementary with cytology? Are any of those any better than NMP-22?

A. Well, you see, as you might gather from the gist of my article, they're all out there and being evaluated at the present time and being compared against each other in the same populations, and we find that there's such a variance in their sensitivity and their specificity reported by different groups around the country and outside of the country that it's hard for the clinician to say at any one point in time that this one is better than this one.

And so at the present time, since basically the only -- the NMP-22 and the BTA are available to the average clinician, the others are basically investigative things.

Q. And what you're saying is, those two have been avail -- they're available to the average clinician in terms of they've been approved for use by the FDA; is that correct?

A. That's correct.

MR. WATTLEWORTH: Object to the form.

BY MR. LEGER:

Q. The others have -- I'm sorry. Have BTA and NMP been approved by use in a clinical doctor by the FDA?

A. It is -- I don't know if it is -- actually, I don't know if it is FDA approved. I know it is available, and I have it in my office --

Q. Okay.

A. -- so I assume that --

Q. And "available" means there's nothing wrong with you using it?

A. That's correct.

MR. WATTLEWORTH: Object to the form.

BY MR. LEGER:

Q. Does it have to be FDA approved for you to use it?

A. I don't think so.

Q. I mean, it doesn't hurt anybody --

A. No.

Q. -- if you use it; right? It's a laboratory test?

A. But FDA approval is what the insurance companies look for, for their willingness to pay for it.

Q. Okay. Now, is the NMP-22 use approved by the FDA?

A. It is, yes.

MR. WATTLEWORTH: Object to the

form.

A. As far as I know, it is approved for use, yes, by the FDA.

MR. LEGER: What was objectionable about the form?

MR. WATTLEWORTH: What type of use?

BY MR. LEGER:

Q. Okay. Is the -- let's see if we can straighten this out. Is the NMPA test approved as a diagnostic tool for urologists to detect bladder cancer?

A. Yes, it is.

Q. By the FDA; correct?

A. (Deponent nods head.)

Q. Okay. And it is available to you, as a urologist, for use in your office in attempting to detect bladder cancer; correct?

A. That's correct.

Q. Okay. Now, in the context of what we talked about, and you provided us -- actually, you provided yourself with, or someone provided to you -- a number of articles regarding these various tests, and those articles apparently investigated the efficacy and the usefulness and the accuracy of -- the various tests we've talked about; correct?

A. Correct.

Q. And you just testified a few minutes ago that there are mixed results in terms of the efficacy of those tests relative to each other --

A. Correct.

Q. -- correct? Generally, though, each one of those that you referred to in your report has been found to be relatively effective; correct?

MR. WATTLEWORTH: Object to the form.

A. Of some value.

BY MR. LEGER:

Q. Of some value, right. And -- but the question in the literature that you spoke of is, what is the relative effectiveness to each other; correct?

A. That's correct.

Q. Okay. Now, in the context of monitoring for bladder cancer in a person who has been found to have hematuria or -- strike that.

In the context of monitoring for bladder cancer in a population of persons who have been found to have hematuria, is a cystoscope a recommendable tool?

A. Absolutely, to the point of being

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indispensable.
Q. And why is that?
A. Well, what's better than direct visualization?
Q. Explain a cystoscope, if you would.
A. Well, cystoscopy presently is performed most often with a flexible cystoscope. A cystoscope has the diameter of about 18 french, which is a little smaller than this pen.
Q. Okay.
A. It's introduced into the urethra after it's anesthetized with Xylocaine, and because it is flexible, it's far more comfortable than that which was used up till maybe even five years ago, which was a rigid rod that you accommodated to rather than it to you and, as such, it's now done as an outpatient --
Q. I'm sorry, Doctor.
A. There's nothing nice that happens in a doctor's office.
Q. Right.
A. It's all uncomfortable and --
Q. Particularly this.
A. Well, I tell my patients every day, there's nothing pleasant that happens in a doctor's

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office.
Q. That's true.
A. Okay? You don't go there for that. So with that acknowledgment, you accede to it. The telescope is then advanced beyond the prostate into the bladder in the male, just simply into the bladder through a short urethra in the female, and you're able to investigate the entire circumference of the bladder, mainly because your cystoscope is very flexible at the tip. Rather than being rigid and having to use oblique lenses and things like that, you can now inspect every bit of it.
So not only do you know that the patient has a tumor, but you know the location of the tumor and the characteristics of the tumor, its proximity to the uretal orifices when you're considering resecting it, etc., etc., etc.
Q. Okay. So in other words, when you use a cystoscope, I mean, you're looking in a camera that's looking inside the bladder, correct?
A. You can. You can. My -- I have an attachment -- a camera that attaches to it so the patient can see on the video what we're looking at or you can look directly into the lens yourself.
Q. I'm sorry. It's almost like using

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a -- I mean, you're simply extending your normal view, correct?
A. Correct.
Q. Can you magnify what you're looking at?
A. It's magnified ten times.
Q. Okay. And you visually examine the wall of the bladder --
A. That's correct.
Q. -- when you do that? There's a little light, I assume, that you can --
A. Very powerful light.
Q. Very powerful light --
A. Fiber optic.
Q. -- so that you can see it. And there are very observable physical characteristics of malignant tumor?
A. That's correct.
Q. Okay. Would you agree with the general proposition that the earlier you can detect the presence of malignant tumor, the better the prognosis?
A. That's a truism; that's correct.
Q. Okay. And that's a general truism in the context of oncology; correct?

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A. That's correct.
Q. And not just bladder cancer; correct?
A. You can say that about all medicine.
Q. Okay. So would you also agree with the general proposition that in the context of malignant tumors, the earlier you find -- you observe the tumor, generally, the smaller it is?
MR. WATTLEWORTH: Are you talking about bladder tumors?
MR. LEGER: I'm talking about tumors in general -- cancer tumors in general.
BY MR. LEGER:
Q. I mean, the cancer doesn't get smaller as it gets worse; correct?
A. Okay. Cancer is not cancer is not cancer.
Q. Okay.
A. Okay? There are grades of tumor. There are different types of tumors.
Q. Right.
A. And there are certain tumors -- 80 percent of bladder tumors are superficial and don't go on to anything more than that, so in that context, you may look at a tumor now and come back

a year later and it'll be the same size.
Q. Okay.
A. That's its natural history. It's not going to grow any more than that. The potential for invasion is there, and since we have no ability to detect whether or not that is going to be invasive, yes, we do attack it at that time and remove it.
Q. So when you say "superficial" and -- I'm sorry -- 80 percent of the bladder tumors are what you call superficial tumors --
A. That's correct.
Q. -- correct? What that means is that they are found only in the -- I guess, the outermost or innermost tissue of the bladder?
A. That's correct. They are in the most superficial layer of the bladder, that being the epithelium, limited by the basement membrane below, which is the submucosa.
Q. If you don't do anything with it, and assume it doesn't evade --
A. Invade.
Q. -- invade other layers of tissue, will it spread in the epithelium?
A. For the vast majority of these

tumors, no.
Q. Okay. So the risk of the superficial tumor, though, is that it will spread to other layers; correct?
A. The risk is the potential for invasion.
Q. Okay. Now, invasion -- now, is there also a risk of metastasis?
A. Not from a superficial tumor.
Q. Okay. Now, once the superficial tumor invades other tissue, does it then have a potential for metastasis?
A. That's correct.
Q. Okay. And at that point, then it's no longer a superficial tumor?
A. That's correct, by definition.
Q. Now, there are also other bladder tumors that, by their nature, are not superficial but rather are invasive?
A. That's correct.
Q. And that -- and hence the distinction that you made earlier between the superficial tumor detection by one test over the other and the invasive tumor detection potential of other procedures; correct?

Was that a bad question?
A. Yeah.
Q. Okay.
A. Can you rephrase that?
Q. I'm not sure I can, Doctor. In other words, I guess, in your mind as a doctor, as a treating doctor -- treating physician in the context of bladder cancer, you categorize the tumors --
A. Yes.
Q. -- and one of the reasons you categorize is because you know, clinically, that some tests are better at finding that type of tumor?
MR. WATTLEWORTH: Object to the form.
BY MR. LEGER:
Q. Correct?
A. No.
Q. Okay.
A. No. When those tests detect a tumor, they don't tell us what grade the tumor is. They just detect the presence of the tumor.
Q. Okay. And by "grade," you mean what, Doctor?

A. What is -- okay. Grade is a pathologic designation based on certain cytologic characteristics; that is, these are characteristics within the cytoplasm of the cell, or within the nucleus of the cell, that are -- have been characterized as having degrees of dedifferentiation; that is, they don't look like the normal parent tissue.
And the more abnormal they look, the higher the grade they are, and we correlate that -- we hope this is accurate -- with what their potential biological activity might be, and so that a higher grade tumor would tend to have a more malignant behavior in the future than a lower grade tumor.
Q. Theoretically --
A. And in general, that's true.
Q. I'm sorry. Generally, you would rather catch, or find and diagnose, the malignant tumor at a lower number grade; correct?
A. That's correct.
Q. If you have your preference --
A. Oh --
Q. -- as a diagnostician?
A. That's correct.

Q. You would rather find it at T-1 –
A. That's correct.
Q. – than find it at T-4/5; correct?
A. That's correct.
Q. And –
MR. WATTLEWORTH: Walter, are we getting to a point where we might take a break?
MR. LEGER: We'll take a break, yeah.
(A brief recess is taken.)
BY MR. LEGER:
Q. Doctor, we're going to go back to this Exhibit A of Cockburn Exhibit No. 1. And we had talked about – a while back about your billing records, and I called for production of those, and I realize you don't have them with you. But in that regard, when were you first retained in this case?
A. I think in May of this year – April.
Q. And how were you first contacted?
A. My contact person with the firm with whom I had dealt with through the Engle case advised me of this pending litigation.
Q. And who is that?

A. Ursula Henninger.
Q. And what firm is she with?
A. This one (indicating).
Q. The firm in North Carolina?
A. That's correct.
Q. She called you on the phone?
A. Correct.
Q. And what did she tell you about this case?
A. Just the nuts and bolts of it; that it was involved with the monitoring of individuals who had been exposed to tobacco.
Q. And what did she ask you to do?
A. Review the data that she would send me, which basically were the reports by, I think, Dr. Wiener and Dr. Sartor.
Q. Okay. Did she eventually also send you a copy of what's – what is called the monitoring program, a document separate from the direct reports of Dr. Wiener and Sartor?
A. And who is the author of that one?
Q. Well, it is a group of doctors and scholars and medical school people, and I'm going to just show you – it's called The Clinical Value of Early Detection and Diagnosis and of Medical

Monitoring. Have you seen that document? It might have been attached to a report of Dr. David Burns.
A. I think so, yes. It looks familiar.
Q. And there is specific reference –
A. Yes.
Q. – to the medical monitoring program. You agree, Doctor, that there's – I'm sorry – medical monitoring regarding bladder cancer is referred to in that document, as well as –
A. Yes.
Q. – several other diseases?
A. Yes, I did see that.
Q. Now, you also saw that there's a little bit more lengthy analysis of the bladder cancer issue, particularly in Dr. Sartor's report; correct?
A. Correct.
Q. Doctor, do you agree that the American Cancer Society states that bladder cancer screening is not recommended for people without symptoms who do not have strong risk factors for this disease?
A. Yes.
MR. WATTLEWORTH: Object to the

form.
BY MR. LEGER:
Q. You do agree?
A. Yes.
Q. And do you also agree the American Cancer Society goes on to state risk factors that would justify a screening include proven exposure to cancer-causing chemicals, earlier bladder cancers, or certain birth defects of the bladder?
MR. WATTLEWORTH: I'm going to object. Just where are you – what are you referring to right now? Are you reading out of a particular report?
MR. LEGER: I'm reading out of Dr. Sartor's report as quoting the American Cancer Society.
MS. WIMBERLY: And, Walter, are you asking if he agrees –
MR. LEGER: If he agrees that's what it says.
MS. WIMBERLY: – that's what it says?
MR. LEGER: That's right.
MR. WATTLEWORTH: That's what his report says?

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MR. LEGER: That's what the report says.
MR. WATTLEWORTH: Right. That's your question, if he --
MR. LEGER: And I'm asking -- no -- if that's what the -- if he agrees that's what the American Cancer Society says.
THE DEPONENT: You know, the American Cancer Society says so, but in their cancer magazine, they say -- the CA, the cancer magazine of the American Cancer Society -- they say nothing about bladder cancer monitoring.
BY MR. LEGER:
Q. Okay. And where do they not say -- I'm sorry -- tell me, again, the name of --
A. The CA cancer journal for cancer detection really has no data on there about bladder cancer.
Q. Okay. Are you talking about on the Internet or are you talking about the volumes or the magazine that you get --
A. The magazine itself.
Q. -- periodically?
A. Yeah.
Q. Okay. Have you researched it to

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determine if there's --
A. Only to look through the ACS Web site.
Q. And you particularly looked for a specific reference to bladder cancer --
A. Yes.
Q. -- correct? Do you recall what search criteria you used or search parameters you used?
MR. WATTLEWORTH: In looking through the American Cancer Society Web site?
MR. LEGER: Web site, yeah.
A. No, just cancer detection.
BY MR. LEGER:
Q. Would you disagree with the suggestion that bladder cancer should not be screened in people with symptoms who do not have strong risk factors?
MR. WATTLEWORTH: Object to the form?
A. Do I disagree that people should not be --
BY MR. LEGER:
Q. Do you agree or disagree with that statement?

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A. Well, I agree that people with risk factors and symptoms should be evaluated for bladder cancer, yes.
Q. All right. How about people with no symptoms but strong risk factors? Do you think they should be monitored?
A. And when you say "monitored," you mean --
Q. I mean, well, screened.
A. And that screening would be?
Q. In any way. I'm talking about any type of screening.
MR. WATTLEWORTH: For any disease?
MR. LEGER: No, for bladder cancer.
A. Yes, I think, and that screening is the urinalysis.
BY MR. LEGER:
Q. Okay. And you would agree that -- or would you agree that risk factors that would justify a screening would include proven exposure to cancer-causing chemicals?
A. And when you say that "screening," are you talking about the average individual who walks into the doctor's office who says, Yes, I work in an aniline dye factory, or, I work for the

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petroleum industry in distillation, or -- those individuals or those individuals walking into a general physician's office should be screened per se?
Q. Let's talk about those, then --
A. Yeah, I figure --
Q. -- if that's what you would like to do.
A. -- they should definitely have a urinalysis.
Q. Okay. Why should people who work in the aniline dye industry be screened?
A. It just has a higher association of bladder cancer in those individuals who are exposed to aniline dyes.
Q. What is the level of association, if you know?
A. That there's a risk associated, higher than normal.
Q. All right. What is the known association in the context of persons who work in the petroleum industry?
A. Again, only a higher association.
Q. Okay. And you would advocate screening in those cases, also; is that correct?

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A. Yes.
Q. Okay. Would you also advocate screening for bladder cancer in the case of persons who have long-term exposure to cigarette smoke?
MR. WATTLEWORTH: Object to the form.
A. I want to just make a qualification here. When someone walks into a doctor's office, and they're coming asymptomatically for a general medical evaluation, they're going to get a screen, if that's the word you want to use.
BY MR. LEGER:
Q. Right.
A. They're going to be screened by a urinalysis.
Q. Right.
A. Now, if the doctor, in the context of that screen, finds hematuria, he's going to be concerned because of the presence of hematuria, and, yes, his anxiety may be heightened by the occupational or whatever social exposure to known carcinogen entities, yes, but that's -- and all that means is that he might, with greater alacrity, send him to a urologist for evaluation.
Q. Okay. My question is, for example,

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in the case of a person who -- or a group of people, for example, that work in a particular aniline dye manufacturing facility --
A. Mmhmm.
Q. -- would you recommend that that group of people be screened, outside of a normal annual physical checkup, for bladder cancer?
A. One has to say, in general, of course, of course. But how long is the exposure? How great is the exposure? These are all variables that have to be brought into the --
Q. Okay. You wouldn't oppose screening people who work in an aniline dye manufacturing facility being screened; correct?
A. I wouldn't, but the secretary on the fifth floor is not necessarily exposed to the dyes.
Q. Okay. So would it be your opinion that if there is an established or known exposure to a cancer-causing chemical, that you would not oppose recommendations of screening for that person or groups of people similarly situated?
MR. WATTLEWORTH: Object to form.
A. If the screening is just a urinalysis, I have no problem with that.
BY MR. LEGER:

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Q. Now, would you also -- in the context of setting up a program, for example, of a group of workers that are directly in contact with the aniline dye chemical in an aniline dye manufacturing facility, and we're talking about, now, constructing a program, would you agree that -- you've already indicated that you would agree a urinalysis would be a good recommendation --
A. That's correct.
Q. -- in terms of screening. Now, once urinalysis is performed, if urinalysis is negative for blood --
A. Right.
Q. -- for hematuria, then you would recommend no further screening or monitoring for bladder cancer, correct?
A. That's correct.
Q. Now, assuming, in such a program, a finding positive for hematuria, would you then recommend further diagnostic testing?
A. For him or anyone else; that's correct.
Q. Okay. And you would not be opposed in that instance to the use of NMP-22 or cytology;

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correct?
A. Not at all.
Q. Okay. Have you provided any written materials -- and, again, we're back to Exhibit No. 1 -- any written materials, documents, writings, or other objects to counsel for R.J. Reynolds or other tobacco companies in connection with your expert testimony in this case?
A. Not beyond what you have a copy of.
Q. Now, in connection with this -- with your report --
MS. WIMBERLY: I don't think you've identified the report --
MR. LEGER: Oh, okay.
MS. WIMBERLY: -- as an exhibit yet, Walter.
MR. LEGER: Might as well identify it, just for the sake of -- because I put all those numbers on those little tags. Might as well use them.
MR. WATTLEWORTH: Yeah, I think you just have to identify the reliance list.
MS. DESUE: And the CV.
MR. WATTLEWORTH: Yeah.
MR. LEGER: Oh, I'm sorry. This is

probably your copy that I just pulled off the table.
MR. WATTLEWORTH: I believe it is.
MR. LEGER: Is that because you -- you got a tag across the top, so --
MR. WATTLEWORTH: Yeah, yeah, that's mine. Do we have another copy of it anywhere? I mean --
MS. DESUE: Let me see if I've got another copy.
MR. WATTLEWORTH: -- we can make a copy of it. That's okay.
MR. LEGER: I'm sorry. I don't --
MS. DESUE: I don't have a blank copy. I stupidly wrote on mine, but I have one.
MR. LEGER: I object to your characterization as your writing --
MS. DESUE: Being stupid.
MR. LEGER: -- being stupid, yeah. And I know you really didn't mean it, for the record, Chris.
MS. DESUE: No, I didn't really.
BY MR. LEGER:
Q. In any event, we're going to attach a copy of that report, Doctor, and I assume -- and

mine is marked, also, but I'm talking about this report --
A. Correct.
Q. -- correct?
MR. WATTLEWORTH: And you're free to use mine to refer to for now --
MR. LEGER: Okay. Yeah, if you would.
MR. WATTLEWORTH: -- if you want, if it'll speed things along.
MR. LEGER: Thank you.
MS. WIMBERLY: And, Walter, that's going to be Exhibit 4?
MR. LEGER: That will be Exhibit No. 4 we're identifying -- marked for identification as Cockburn No. 4.
BY MR. LEGER:
Q. Doctor, was that report typed in your office?
A. Yes, it was.
Q. Okay. Was -- before a final draft was prepared, was it sent to anyone for review?
A. Yes, it was.
Q. Who was it sent to?
A. Mr. Wattleworth.

Q. Did he make any changes?
A. Yes. We made some typographical changes and asked me to clarify my feelings about the -- specifically about the screening evaluation for which individuals in particular.
Q. What part of that -- of your report would that be? The --
A. Fourth --
Q. -- fourth paragraph?
A. -- paragraph down.
Q. So he suggested that you add on that last sentence; is that correct?
MR. WATTLEWORTH: Hold on a second. Let me see -- take a look at this.
A. In the context of, did I know of any --
BY MR. LEGER:
Q. Right.
A. -- recommended cancer screening --
MR. WATTLEWORTH: Wait. I'm --
A. -- specifically for smokers, no.
MR. WATTLEWORTH: Okay. Just so I'm clear, since I didn't have this report in front of me when you asked that question -- 1, 2, 3 -- fourth paragraph, you're saying -- your question

was, did I suggest that he add that last sentence on there? Is that what your question is?
MR. LEGER: Yeah. I'm not asking you, though.
MR. WATTLEWORTH: I know you're not, but I didn't have the report, so -- and he said -- okay. And his answer was no. Okay.
MR. LEGER: Well, I'm not sure that was his answer.
MR. WATTLEWORTH: The problem is, now that I've given you my report, I don't have a copy to look at.
MR. LEGER: I'm sorry. Take all the time you need, Counsel, before you answer that question.
MR. WATTLEWORTH: Go ahead.
BY MR. LEGER:
Q. No, I'm simply wondering, did he ask you to give the opinion on that subject matter? I'm not trying to play games.
A. Yeah, I know. He asked me my opinion on that, do I know --
Q. Lawyers do that, and I'm not even saying there's anything wrong with that. I'm just wondering --

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A. Okay.
Q. -- if he asked you to add that -- an opinion on that subject.
A. He asked for my opinion on that subject, yes.
Q. Okay. And your opinion, as it states, is that you're not aware of a medical association which advocates bladder cancer screening for smokers who are asymptomatic or without hematuria --
A. Correct.
Q. -- correct? And you've already given the opinion that you have no problem with those exposed to environmental cancer-causing agents being screened if they have hematuria; correct?
A. That's correct.
Q. Okay. Are you aware of any major medical associations which advocate against bladder cancer screening for smokers, period?
A. No.
Q. Or question mark, rather. Are you aware of any major medical association which advocates against bladder cancer screening for smokers with hematuria?

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A. No.
Q. Now, you are aware that there are groups or organizations that advocate against cystoscopy as a method of screening; correct?
MR. WATTLEWORTH: Object to the form.
A. Screening for whom?
BY MR. LEGER:
Q. Screening for bladder cancer.
A. In patients who are --
Q. In an asymptomatic patient.
A. Without hematuria?
Q. Yes, sir.
A. I'm also against that.
Q. Okay. And why?
A. What's the need?
Q. Okay. The -- okay. My next question is, would you also oppose the use of cystoscopy in screening in a person exposed to environmental carcinogens who have no symptoms?
A. And when you say -- again, is that using cystoscopy for that screening?
Q. Yes.
A. Without hematuria, there is very little indication for doing a cystoscopy, so I am

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opposed; correct.
Q. You would agree, generally, that cystoscopy is not a recommended form of screening, period; correct?
MR. WATTLEWORTH: Object to the form.
A. See, we're --
BY MR. LEGER:
Q. Yes.
A. -- skipping around the word "screening" here --
Q. Yes. Okay.
A. -- and, again, I believe that the urinalysis is the screening test.
Q. Okay.
A. Okay? You are guilty until proven otherwise if you have blood in your urine, and it's --
Q. Right.
A. -- my responsibility to find the tumor, so yes.
Q. That's the threshold primary screen --
A. That's correct.
Q. -- correct -- urinalysis?

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A. That's correct.
Q. And then you work your way down the ladder and you continue to screen --
A. That's correct.
Q. -- and with different tests and different procedures, and at some point, even, a cystoscopy can be both a screen and/or a diagnostic tool; correct?
A. When you say "screen," it is diagnostic. It is -- I don't think of it as screening.
Q. Okay.
A. At that point, that person is -- has something that I have to find the reason for --
Q. Okay.
A. -- so it's no longer a screen.
Q. And, in fact, cystoscopy is invasive; correct?
A. That's correct.
Q. And it's quite expensive, relative to other forms of screen, like urinalysis; correct?
MR. WATTLEWORTH: Object to the form.
A. I don't know what the cost of an NMP-22 is, but I think cystoscopy costs as much as

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a cytology does.
BY MR. LEGER:
Q. Okay. How much does –
A. Cytology?
Q. – cystoscomy –
A. Cystoscopy?
Q. – cost? Forgive my – I'm really having trouble with this word, and I've been practicing, Doctor.
A. Sure. "Cyst-o-scope-y".
Q. "Cyst" –
A. "Cysto" is for bladder –
Q. – "o-scope-y."
A. – and "scopy" is to look. Now I forgot the question.
Q. So did I, Doctor. The cost –
A. Oh, oh.
Q. – of cystoscopy.
A. I think Medicare pays about $120 for it.
Q. How long does it take?
A. Less than ten minutes.
Q. Generally outpatient?
A. Almost always.
Q. And you have no materials, no

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documents whatsoever, directly related to either Ms. Jackson or Ms. Scott?
A. No, sir.
Q. Do you have any correspondence with the lawyers for Reynolds or other tobacco companies, including but not limited to, electronic mail?
A. No.
Q. You did not communicate by Internet?
A. No.
Q. They send you any letters other than enclosure-type letters?
A. None.
Q. Did they send you enclosure letters?
A. Enclosure letters, yes.
Q. Enclosed is a copy of?
A. Correct.
Q. Did you send them any, enclosed is a copy of?
A. No, other than the report.
Q. Did the report have an enclosure letter with it or did you just send it to them?
A. No, I just sent it.
Q. You mailed it to them or sent it by Internet?

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A. Mailed.
Q. Or fax or otherwise?
A. Faxed and then mailed.
Q. Okay. Do you keep copies of your fax receipts and that type of thing?
A. No.
Q. Have you made any speeches or public statements or participated in any lectures in connection with bladder cancer?
A. Yes.
Q. Where and when?
A. The last one was in February of this year in a forum sponsored by a drug company for a health fair for African-American males.
Q. And you spoke about bladder cancer?
A. (Deponent nods head.)
Q. Was that –
A. Bladder and prostate cancer.
Q. Did you prepare a paper?
A. I had notes, but I didn't – I spoke extemporaneously.
Q. Okay. Did you keep your notes?
A. No.
Q. What was the general gist of the discussion?

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A. How we contribute to our health or unhealth; basically, just diet, nutrition, exercise, da-da-da-da-da-da.
Q. Did you talk about smoking?
A. Of course.
Q. Did you point out that smoking is a high risk factor in both prostate and bladder cancer?
MR. WATTLEWORTH: Object to the form.
A. I mentioned that it is a risk factor, but far more so for heart disease and impotence, which concerns most men.
BY MR. LEGER:
Q. Is smoking a factor in impotence?
A. Yes, sir.
Q. A major factor?
A. A contributing factor.
Q. What's the etiology of that? You're right; it is of interest.
A. Only in that studies have shown that there's an accelerated arteriosclerotic component to heart disease in smokers, and that is the bottom baseline of heart disease.
Q. Did you talk about smoking being a

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major risk factor in connection with lung cancer?
MR. WATTLEWORTH: Object to the form.
A. No.
BY MR. LEGER:
Q. What are the known and scientifically accepted risk factors in connection with bladder cancer?
A. You're talking about environmental and industrial exposure?
Q. I'm talking about whatever risk factors the medical community and scientific community consider.
A. Well, the most common cause of bladder cancer in the world is schistosomiasis.
Q. Which is what?
A. Which is an infection with the schistosoma larvae, which then enters your vascular system and then ends up with the larvae in your bladder. That causes chronic inflammation and, eventually, development of squamous cell carcinoma of the bladder.
Q. Okay. How about in the United States?
A. In the United States, there's a very

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high association of bladder cancer in areas in which there is a major industrial petroleum industry with distillation and refineries. New Jersey, Louisiana have high incidence of bladder cancer in that association.
The aniline dye industry has always been known to be involved with it. Smoking, we know, has a higher incidence of bladder cancer in individuals who smoke heavily over a long period of time. Just about anything that has to do with hydrocarbons -- people who are involved, let's say, in motor pools of truck companies, bus companies, even taxi drivers -- have a higher incidence of bladder cancer.
Q. What -- by the way, what is aniline dye?
A. Aniline is a -- hmm. It's a component of dyes.
Q. Of all dyes, generally, or most dyes?
A. No, most dyes.
Q. And aniline is the chemical in the dye that --
A. That's correct.
Q. -- is believed to be carcinogenic?

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A. That's correct.
Q. In your deposition in the Engles case, you indicated that you had relied upon about 40 or 50 documents or articles or journals in connection with the opinions you gave in that case; is that correct?
A. That's correct.
Q. Did you rely upon those in the context of the opinions you've given in this case as well?
A. Not to have specifically reviewed them, but the general knowledge that I got from them.
Q. What did the -- what was the subject matter, generally, of that group of articles? I assume it was somewhat different than the subject matter of these.
A. Well, there's a problem defining what is carcinogenic and what is not, relative to bladder cancer, and the multiple sources of carcinogens in the environment that contribute to the development of cancer and the incidence of cancer in certain individuals in certain parts of the country --
Q. Mm-hmm.

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A. -- and the complexity of it all, such that we don't still know what is the actual causative factor of bladder cancer relative to, say, smoking.
Q. Okay. So may I understand what you're saying is that in the Engle case, the issue that you dealt with was whether or not smoking causes bladder cancer?
A. That's correct.
Q. And your opinion was that there isn't sufficient scientific data to establish smoking as the cause of bladder cancer; correct?
A. That's correct.
Q. But you also agreed that smoking is a known cause of bladder cancer --
A. Definitely.
Q. -- correct? And you also agreed in that case that cigarette smoking significantly increases the risk in a person to bladder cancer over that of a normal -- over that of a nonsmoker; correct?
MR. WATTLEWORTH: Object to the form.
A. With the only modification of the amount of smoking and the duration of smoking.

A. Well, yes, you could call cystoscopy surgery, but it's -- I don't consider it surgery unless I cut something --
Q. Okay.
A. -- in the course of cystoscopy. If you have a bladder tumor, I'll -- I can remove it through the cystoscope, and that is a surgical procedure. The actual --
Q. Is that called a cystectomy --
A. No.
Q. -- or is that different?
A. Cystectomy means removing the whole bladder.
Q. Ah, okay.
A. Okay? Here would just be a tumor resection. It would be cystoscopy with tumor resection.
Q. Okay.
A. And then that has to be performed under anesthesia -- general anesthesia.
Q. Okay. And are those the forms of surgery that you do today?
A. Yes. I am -- or if the patient were to have invasive bladder cancer, he would have to have his bladder removed, and then make him a new

BY MR. LEGER:
Q. The -- is it your testimony that the scientific data suggests that the incidence of bladder cancer in smokers is relative to duration of smoking and the amount of cigarettes they smoke?
A. Correct.
Q. So there is a dose response, effectively --
A. That's correct.
Q. -- correct? And that's true of many carcinogens in the context of causation and cancer; correct?
A. That's correct.
Q. In fact, that's one of the principal characteristics of a carcinogen; correct? The chance of developing cancer is related to dose and response?
A. That's correct.
Q. Doctor, I'm going to refer you to your curriculum vitae at this time -- you probably don't need to look at it, but I do -- and just ask you a few questions there. You have some specialized training in urological oncology; correct?
A. I do.

Q. And would you tell me about that training?
A. It's a clinical fellowship I did at the Memorial Sloan Kettering Hospital in New York from 1980 to 1981 in which my clinical research actually was looking for bladder tumor antigens in the urine and -- but that was the laboratory research. My clinical was -- basically was surgery of the bladder, kidney, prostate.
Q. What does that mean, your clinical was surgery? You actually performed surgery?
A. I did the surgery, yes.
Q. Do you do surgery now?
A. Oh, yes.
Q. Now, by surgery, you include -- in the definition of surgery, we often think -- we lay people think of surgery as cutting with a knife.
A. That's correct.
Q. But there's also other forms of surgery --
A. Right.
Q. -- like cystoscope?
A. Right.
Q. That is what you call surgery. And what else? What other types of surgery do you do?

bladder out of his colon. That's part of my surgery, too.
Q. And you do that type of surgery, also.
In the context of your curriculum vitae, at Columbia you were an assistant professor of urology. What does that mean?
A. Well, it's a step above --
Q. What's an assistant professor?
A. -- a step above instructor and one below associate professor.
Q. Okay. I mean, did you teach classes?
A. No. In that context, a clinician or an academician is teaching medical students in the hospital, not in a didactic setting in a classroom per se.
Q. Mm-hmm.
A. You teach them on rounds, you teach them in the operating room -- in that way.
Q. So while in that capacity, you were basically an employee of the hospital or the medical school?
A. Yes.
Q. And not in private practice?

A. That's correct.
Q. Okay. Now, since 1985, you've been at the University of Florida in Tampa; correct?
A. South Florida, yes.
Q. I'm sorry. South Florida in Tampa. And -- but you have also been in private practice; is that right?
A. Right. So my association with the university is a clinical appointment, and that means I don't get paid but I do pretty much the same thing in terms of teaching residents.
Q. So you don't stand up in front of a classroom of med students and lecture them --
A. No.
Q. -- with a blackboard and that kind of thing?
A. No.
Q. And so do I understand that basically you have privileges at the University of South Florida Medical Center or some facility?
A. Tampa General Hospital, which is their main teaching hospital, yes.
Q. I mean, is there an actual University of South Florida medical school?
A. No.

Q. Okay. Are there any professors of urology at the University of South Florida?
A. Yes.
Q. Are they paid, also -- are they paid?
A. They are paid.
Q. Okay. A clinical assistant professor is not, correct?
A. Correct.
Q. Would an assistant professor be paid?
A. Yes.
Q. And there are --
A. Yes.
Q. -- assistant professors?
A. Yes.
Q. And those people, either a professor or an assistant professor, do not have private practices?
A. Correct.
Q. Okay. And the next step -- professor or assistant professor -- is there an associate professor?
A. Yes.
Q. And is that person paid?

A. No. When you have "clinical" in front of it, you're not being paid.
Q. Okay. And so you go from professor, assistant professor, associate professor, and then clinical assistant professor; correct? That's --
A. You can be a clinical associate or clinical professor, too.
Q. Okay. That's enough for me. It's getting beyond my mental capacity to understand.
The Tampa General Hospital, I assume, is not the only hospital at which you have privileges today --
A. That's correct.
Q. -- correct? And those privileges are listed under --
A. Yes.
Q. -- hospital affiliations? Now, I'm also -- I'm looking at unpublished presentations at major medical meetings, and you list -- 1, 2 -- three. Do any of them have to do with bladder cancer?
A. No.
Q. Any of them have to do with cancer at all? If you want to --
A. Yes, all were involved with

cancers. The first one was the germ cell tumors of the testicle, the second was treatment of prostatic carcinoma, and the third one was also germ cell tumors of the testicle.
Q. None of these articles had anything to do with medical screening or diagnosis in relation to bladder cancer; correct?
A. That's correct.
Q. None of them had to do with the analysis of -- or principles of screening, or particularly the tools of screening or otherwise --
A. No.
Q. -- correct? And in the context of your publications, may I assume that the last publication you were involved in was 1984?
A. That's correct.
Q. And none of those publications had to do with bladder cancers, except for perhaps No. 6?
A. That's correct.
Q. And that was in 1984?
A. That's correct.
Q. Was there any analysis in that article of predicting tools?
A. No. They weren't available at that

time.
Q. So these tests that we talked about and that you talked about, really, in your report -- NMP-22, BTA Stat, FDP, Telomerase assay, and others -- and the search for markers in P 53 gene, etc. -- are relatively new developments, in the '90s, perhaps?
A. That's correct.
Q. Particularly, the latter part of the '90s; correct?
A. That's correct.
Q. Do you particularly have any opinion as to whether or not there are currently very promising emerging technologies in the context of laboratory tests to predict and find bladder tumor?
A. Beyond those that were mentioned here?
Q. Yes, sir.
A. Oh, I'm certain that there are. I know that there are. Now that the human genome project has been completed, there are a number of different probes that are being exploited to look into what really is cancer, how cancer starts from the beginning, what are the signals that turn them on; and then as we learn more about the signals,

where we can modulate them or -- and gain further insight into what we want to know, mostly not so much as whether or not there is a cancer there as what is the malignant potential of that cancer in particular; how scrupulously do we have to monitor that patient?
Q. And by "scrupulously," you mean how closely you should monitor for fear of growth of --
A. No.
Q. -- spreading --
A. We have to do cystoscopy on every single one of them every three months. We're trying to reduce the number of cystoscopies that we have to do, for all of the reasons you mentioned before.
Q. What you would prefer to do in a patient with a high risk of bladder cancer or a malignant tumor is to monitor in some way by laboratory test as opposed to continue to do periodic cystoscopies; right?
A. Yes and no, but, you see, you still have to do the cystoscopy. If the tumor marker comes back positive, what you might do is, instead of saying, Listen, I'm going to -- I want to see you in my office in three months, you schedule them

for the hospital in three months so that you do your cystoscopy under anesthesia because you may be resecting a tumor at that time. That way, you obviate the need for doing it twice.
Q. Okay. And the importance, then, of the other diagnostic tools, the laboratory tools, are to, prior to that scheduling in the hospital in six months, be able to monitor progress, etc.; is that correct?
A. That's correct.
Q. Now, other than the deletion of manuscript in preparation on your curriculum vitae, no other significant changes that we ought to be aware of; correct?
A. No, other than the change of the name of the hospital on page 2 on the bottom from Centurian Hospital is now University Community Hospital. Same hospital, different name.
Q. Okay. An attending urologist just means that you're a urologist in private practice that has privileges at the hospital?
A. Privileges to practice at the hospital; correct.
Q. Now, by "private practice," I assume that means you have a private office that has your

name on it --
A. That's correct.
Q. -- the offices of Dr. Cockburn?
A. Correct.
Q. Do you have any particular checklists or forms that you have patients themselves prepare in context of history or otherwise --
A. Yes, I do.
Q. -- when they come to your office? Can we -- we asked for that -- I believe we did -- and I believe that's what this is in here, and I was wondering if we can get a copy of those.
A. You certainly can.
MS. WIMBERLY: Walter, which part of the subpoena are you referring to?
MR. LEGER: That would be No. 25 -- well, I'm sorry. No, it's not No. 25. It's No. 24 -- no, no, I take that back. Let me look at it.
MS. DESUE: I think it's -- keep going.
MR. LEGER: Yeah, it's No. 28. And actually what I'm looking for is 28, 29, ultimately, and I'm going to ask about that.

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MR. WATTLEWORTH: So right now you're wanting the history? You're asking for the history?
MR. LEGER: Actually, I want everything we asked for.
MR. WATTLEWORTH: Yeah.
MR. LEGER: But I'm asking specifically --
MR. WATTLEWORTH: Right now, you're talking about the history.
MR. LEGER: -- just now about what the patient fills out.
MS. WIMBERLY: I think we have given you everything other than the billing, and then, quite frankly, this is something that I don't think any of us had ever focused on in the context of the subpoenas.
MR. LEGER: Okay. Well, except that -- and I'm not quibbling with you, except that this subpoena form is a form that you sent to our witnesses that we just received. And I don't mean that you did, Ms. Wimberly, but lawyers for the tobacco companies sent, I would suggest obnoxiously, to some of our first witnesses, and we don't -- we obviously don't mean it obnoxiously.

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We just thought that since you guys were interested in them, we ought to be interested in them, too.
MR. WATTLEWORTH: Can we just agree that --
MR. LEGER: And we can strike that colloquy, if you --
MS. WIMBERLY: And I might tell you, Walter, we haven't seen a single one from any of plaintiffs' witnesses either. I think everybody's just kind of overlooked that particular item.
MR. WATTLEWORTH: I was going to suggest that perhaps we handle the request on the subpoena consistently with how we've been handling them up to this point.
MR. LEGER: Well, I would suggest we not, because there hasn't -- there's been nothing consistent about it.
MR. WATTLEWORTH: I mean, it sounds like --
MR. LEGER: But I think, generally, we have been trying to -- we've been trying to get consistent.
MR. WATTLEWORTH: Okay. Well, we'll --
MR. LEGER: And I'm not trying to

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start a controversy or even document a controversy other than just I want to confirm that we -- I don't think we've had any real firm agreement other than I thought we agreed to provide everything three days prior to, and we've been attempting to.
MS. WIMBERLY: And our understanding was simply three days prior we were providing reliance and attempting to provide prior testimony and files, but --
MR. LEGER: And --
MS. WIMBERLY: And certainly this is something we can get.
MR. LEGER: Yeah, right.
MS. WIMBERLY: I'm sure it's a standard form.
MR. LEGER: And it's really not that important in all of them. We've been using these forms as pertinent.
BY MR. LEGER:
Q. And I guess, in particular, Doctor, let me ask you about that. In the form in your office that the patient is asked to fill out -- and I assume it's like the typical doctor's -- there's, like, a clipboard or something, and there's some form; you sit there and you fill it out yourself?

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A. Four pages.
Q. Four pages. Is there any question regarding smoking history?
A. Yes.
Q. And what does that involve? Does it just ask, Do you smoke, or --
A. Do you smoke and how much and, if you stopped, how long ago.
Q. And is that a form that you developed yourself?
A. Yes.
Q. And why is that on the form?
A. It's important.
Q. Why is it important?
A. Well, it's for all the potential risk problems that have been well documented in the past, you know, general health, etc.
Q. Including, particularly, the risk of smoking related to bladder cancer, correct?
MR. WATTLEWORTH: Object to the form.
A. Not really.
BY MR. LEGER:
Q. Okay.
A. Blood in the urine is such a red

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flag to us that – for so many other things. Bladder cancer may turn out to be 1 percent of all the people who do have something positive in their evaluation for hematuria. So it's not the first thing on my mind, but as a urologist, it's up there.

Q. It's certainly one of the things you worry about most, though, isn't it, Doctor?

A. Certainly.

Q. And certainly one of the things the patient worries about the most; correct?

A. I don't think patients worry about it enough, no.

Q. Okay. Doctor, let me talk to you a little bit about prostate cancer and the PSA.

A. Okay.

Q. Does the smoking present a high risk factor for prostate cancer?

A. Not in any epidemiological study that I've noted.

Q. Okay. The -- what is the – how is a PSA performed?

A. Simply a blood test.

Q. And there's laboratory testing to look for what in the blood?

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A. Looking for PSA. PSA is prostate specific antigen. It's an antigen in the blood that is identifiable by antibody – antigen complex techniques.

Q. Okay. Is the PSA recommended as a screening methodology to the general population of males?

A. Only by the American Urological Association, not by the American Family Practice Association.

Q. Do you know why there is a recommendation by the urologists but not the family practice people?

A. Well, it's our bailiwick. That's what we are charged to protect and defend against, and we see a higher incidence of it, obviously, because that's our specialty, and so our concerns are skewed in that direction. Family Practice Association feels that the incidence of prostate cancer is not high enough that warrants a general statement that everyone should have it on the regularity that has been proposed by the AUA.

Q. Okay. Is there a particular risk factor that would – in the view of the field of urologists – that would be suggestive of a PSA?

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A. That was suggestive of the need for a PSA, yes.

Q. And what is that?

A. That's genetics, whether or not a blood relative had had prostate cancer.

Q. Anything else? Environmental exposures? Age? Anything else?

A. No. Age is almost a truism, because any man – the incidence of prostate cancer rises to almost 70 percent in men over the age of 80, so it's common.

Q. The incidence being that men – that –

A. There's an age-related –

Q. – 70 percent of prostate cancers are found in men who are over 80?

A. No. Put it the other way.

Q. That in men over 80, 70 percent of them have prostate cancer?

A. That's correct.

Q. How about men over, like, 48?

A. One in three. There are four of us in here.

Q. I think only two of us are over 48, Doctor.

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A. That's true.

MR. WATTLEWORTH: I'll mark it on my calendar.

MR. LEGER: And, for the record, I'm not admitting that I'm over 39. That's my story, I'm sticking to it, and I'm not under oath, Doctor.

BY MR. LEGER:

Q. As a part of your normal checkup of a person – well, strike that.

When a person comes to see you, are they ordinarily referred by another physician for the first-time visit?

A. I'd say 50 percent of my practice is referral, yes.

Q. Where do the other 50 percent come from? How do they get to you?

A. When you say "referred," you mean by another physician? The other 50 percent come word of mouth or their own knowledge that a urologist is indicated for sexual dysfunction, urinary tract infections, incontinence –

Q. I guess that's my question. How does the ordinary person get to a urologist?

A. Yeah.

Q. Is it the -- 50 percent of them, you said, are generally referred by perhaps a general practitioner or someone who's treating them for something else; correct?
A. That's correct.
Q. Or a general practitioner who observes urological symptoms?
A. That's correct.
Q. The other 50 percent come to you with some other reason; they even have an idea --
A. Their own sophistication and knowledge of medicine.
Q. Okay. When you see a patient for the first time, you take, I assume, a pretty detailed history?
A. That's correct.
Q. And you -- do you perform any particular tests?
A. Yes.
Q. And I'm talking about a patient that comes to you not referred for specific testing or a look by another doctor --
A. Yes.
Q. -- correct?
A. Yes.

Q. What tests do you perform as a matter of course?
A. A physical examination, from blood pressure onward, and depending on the complaint, a urinalysis for everyone. If someone comes in complaining of sexual dysfunction, I probably won't look at his urine.
Q. Okay. Do you do a PSA?
A. If they're over 50 and they -- if they haven't had one in the past year.
Q. And the reason you do a PSA for males over 50 is that because there is statistically and epidemiologically shown a very high risk of prostate cancer?
A. That's correct.
Q. Okay. I'm going to -- do you have -- no, you don't have this before you. I'm just going to go through a number of tests and ask if you have any association in your ordinary practice with performing these or reading it.
You certainly don't have any involvement with doing a needle biopsy of the lung; correct?
A. No, sir.
Q. Bronchoscopy?

A. Nothing above the waist.
Q. Nothing above the waist.
MS. DESUE: That's cute.
BY MR. LEGER:
Q. Nothing to do with the -- with stress testing, any cardiographic testing whatsoever?
A. I may stress some individuals, but, no, I don't --
Q. All right. You perform cystoscopy?
A. I do.
Q. Intravenous pyelography?
A. No. I order that. That's a --
Q. Okay.
A. -- radiological test.
Q. Okay. But that's something that you observe and you supervise, and it's pertinent to your practice?
A. That's correct.
Q. CT scans?
A. No.
Q. What's a VAT wedge? Is that something in your practice?
A. No.
Q. Okay. I didn't think so. Do you --

is testing of the blood for lipids pertinent to your practice?
A. Not regularly.
MR. LEGER: If you'd like to take a break, the videotape is near the end and this is a logical point.
(A brief recess is taken.)
BY MR. LEGER:
Q. Doctor, in the context of your ordinary office visits with patients, if you observe a smoking history of a patient, do you talk to them or counsel them with regard to smoking itself?
A. I do, depending on the level of smoking that they admit to.
Q. And what form does that counseling take?
A. Well, if I see that they smoke excessively -- and to me, excessive is more than, say, a half a pack a day -- then I will counsel them and explain to them their risks for cardiovascular disease, lung problems and, remotely, bladder cancer.
Q. Do you -- have you ever had occasion, in your treatment of individuals, to

refer patients for assistance in cessation of smoking?
A. Have I referred -- yes, I have.
Q. And tell me about that.
A. When someone smokes excessively and is having problems from that, then I strongly suggest that they stop and then recommend one of the various means that are available to help them stop, from Zyban to counseling.
Q. Do you prescribe Zyban?
A. No, I don't, because the follow-up is more complex than I want to be involved with.
Q. I mean, do you get to the point of recommending particular modalities to assist in stopping a smoker?
A. I don't -- I feel that I educate them more than recommend them, and then recommend them to an internist for smoking cessation.
Q. You don't refer them to a psychiatrist, do you?
A. No.
Q. You believe that the family care physician is the primary treater for smoking-related problems in the context of the smoking itself?

A. Yes, because I see it as a mechanical habituation, and I think that drug therapy works fairly well with it. People -- I wouldn't send them to a psychiatrist for smoking, but people who smoke tend to smoke because of emotional problems that they may have, so from that standpoint, I will send them, and smoking is just a symptom of their general pathology.
Q. Do you know that the Surgeon General has declared that smoking is an addictive activity?
A. Oh, I'm sure it is.
Q. And you don't disagree that nicotine is the addictive agent in cigarettes?
A. I think that the data -- and I'm not an addictologist -- shows that the act of smoking -- and whether or not it's specifically nicotine, I don't know, but -- that the act of smoking is habit forming and that some form of addiction can occur.
Q. Are you familiar with the -- would you agree that it is the Surgeon General's and the United States Public Health Service definitions and opinions regarding the addictive nature of nicotine which are the factors which define the term "nicotine addiction" as it is commonly used today

in the medical and scientific community?
MR. WATTLEWORTH: Object to the form.
A. I don't know -- I specifically don't know where that comes from or if it's attributable to the Surgeon General. I know that smoking is an addictive behavior, yes. So is eating.
BY MR. LEGER:
Q. So you believe that smoking is an addictive behavior like eating?
A. I think that anything that feels good or gives pleasure is potentially addictive.
Q. Okay. What is your definition of addictive? Was that it?
A. Mine, I guess, would be a dictionary definition, and that is a physiological or psychological dependence on a substance or action that the individual feels incapable of stopping by himself.
Q. Okay. Now, you are aware that the health care community has determined that nicotine has psychoactive properties; correct?
A. That's correct.
Q. And you would also agree that nicotine has reinforcing properties; correct?

A. What do you mean by that?
Q. That the -- are you familiar with the term "reinforcement"?
A. No.
Q. The medical term? Are you an expert in addiction?
A. By no means.
Q. Are you an expert in the field of substance dependence?
A. No.
Q. Do you intend to offer opinions regarding the addictive properties --
A. No.
Q. -- of nicotine at trial in this case?
A. No, sir.
Q. Have you read the Surgeon General's reports regarding cigarette smoking?
A. No.
Q. Do you intend to?
A. Excerpts of it.
Q. I'm sorry?.
A. Excerpts, I've read, but, no, I don't plan to read the whole thing.
Q. Have you ever treated persons in

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your medical practice who have problems with the use of drugs such as heroin --
A. Yes.
Q. -- cocaine, alcohol?
A. Yes.
Q. Do heroin or cocaine or alcohol have any particular significance in the context of your practice when used by patients?
A. Only in a complication of potential anesthesia.
Q. Now, have you -- I assume you do no particular counseling with regard to patients who use cocaine, alcohol, heroin, or other opiates in connection with their use of those drugs?
A. No.
Q. Is there a place on your form or your checklist when you see a new patient asking them regarding the use of drugs?
A. No -- yes, there is one in the general form asking what drugs they are taking, but --
Q. You don't ask, Are you using heroin? Are you using cocaine?
A. No, I don't.
Q. How, in the ordinary course, would

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you -- in a typical case -- would you come to find out that a patient is using one of those drugs?
A. Either I suspect it and I ask it or the patient will tell me, I'm a reformed alcoholic or reformed drug abuser.
Q. Have -- in the course of your practice, have you observed physical properties or characteristics of smokers which suggest that they are smokers, I mean, in terms of you observing without them telling you?
A. Sure.
Q. Sight, smell, touch?
A. Sure. Tobacco smoke on their breath, a pack of cigarettes in their pocket, yellow fingers.
Q. Yellow teeth?
A. We're in the South.
Q. Or stained teeth?
A. Yes.
MS. DESUE: We're in the South, you said?
BY MR. LEGER:
Q. Holes in their clothing, that kind of thing, from cigarette burns?
A. Maybe at the VA, but not in my

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practice.
Q. My real question is that there are observable features sometimes of cigarette smokers; correct?
A. That's correct.
Q. Would, in the ordinary course of your treatment, you make an observation in the record if a person has not indicated they're a smoker to you on the forms or by history, but you observe characteristics of a smoker?
A. No.
Q. So the significance to you as a clinician is the self-reporting aspect; correct?
A. Yes.
Q. I assume you do not intend to offer yourself as an expert in pulmonology?
A. No, sir.
Q. Or in lung cancer?
A. No.
Q. Or cardiology?
A. No.
Q. Surgery above the waist?
A. No.
Q. Do you regularly treat children?
A. No longer. I stopped about two

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years ago.
Q. And why was that?
A. Kind of almost turf battles now. Now, there are a sufficient number of pediatric urologists such as to make it less common that I would see problems in children, and the -- and I would be only seeing the simple things, like circumcisions or things like that. More difficult ones would go off, and I would send them myself, to the pediatric urologist.
Q. Okay. Do you know any of the expert witnesses in this case?
A. None.
Q. Do you know Dr. Roy Wiener?
A. No.
Q. Have you met any of the defendants' expert witnesses in this case?
A. No, I haven't.
Q. Do you know Dr. Maltsby?
A. No.
Q. You ever heard of him?
A. No.
Q. Do you intend to be -- have you been told when the trial in this case will begin?
A. No.

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Q. Do you understand that this case is a class action on behalf of all Louisiana smokers?
A. Yes.
Q. And you understand that the members of the class are seeking to be able to benefit from a program of smoking cessation?
A. Okay.
Q. Is that your -- did you know that before I --
A. Yes.
Q. Okay. So you've seen the monitoring program --
A. Yes.
Q. -- and seen that it has several parts?
A. Correct.
Q. One is a smoking cessation program; correct?
A. Correct.
Q. And the other are monitoring or screening provisions regarding bladder cancer, lung cancer, coronary artery disease, and COPD, chronic obstructive pulmonary disease; correct?
A. Correct.
Q. All right. Are you in a position to

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offer opinions regarding any of the areas of the medical monitoring program other than bladder cancer?
A. No.
Q. Are you familiar with the provisions of the Guide to Clinical Preventive Services?
A. I've read it.
Q. Is that something that you would have read ordinarily in your practice?
A. No.
Q. And you read it merely in connection with testimony in this case; correct?
A. That's correct.
Q. And you read the provisions regarding recommendations in connection with bladder cancer?
A. Yes, sir.
Q. And what are those recommendations?
A. Oh, I'd have to read it again.
Q. Okay.
MR. LEGER: Do you have a clean copy of it?
MS. DESUE: Yes, I do.
BY MR. LEGER:
Q. What do you know about this thing,

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this Guide to Clinical Preventive Services?
A. What do I know about it?
Q. Yes, sir.
A. Other than having read it?
Q. Yes, sir.
A. I don't understand the question.
Q. Had you ever heard of this thing before --
A. No.
Q. -- this case?
A. No.
Q. And so you didn't find it on your own --
A. No.
Q. -- did you? You didn't look it up as a research source?
A. No.
Q. You were -- this was given to you by tobacco lawyers; right?
A. That's correct.
Q. Is -- would you agree that this Guide to Clinical Preventive Services is not something that is ordinarily used by practicing physicians?
MR. WATTLEWORTH: Object to the

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form.
A. As a guide, no, but the general principles within are well accepted.
BY MR. LEGER:
Q. Okay. But I mean -- but in terms of finding the principles, to determine the principles, the typical practitioner doesn't look for this guide --
A. No.
Q. -- is that correct?
MR. WATTLEWORTH: Object to form. I just want to -- are you talking about any practitioner or a urologist?
MR. LEGER: I'm talking about in his observation; right.
BY MR. LEGER:
Q. Okay. Well, let's break it down, then. Urologists don't -- when they're trying to think of what are we going to do to try to prevent disease, they don't go to the Guide to Clinical Preventive Services, do they?
A. No.
MR. WATTLEWORTH: Object to the form.
BY MR. LEGER:

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Q. To your -- you're also an internist; correct?
A. No, no. I'm a urologist in general urology only.
Q. You're board-certified in urology?
A. Correct.
Q. And do you have -- in the context of your experience, do general practitioners and family practitioners, in general, turn to the Guide to Clinical Preventive Services to determine the principles on which they base their practices?
A. They might.
Q. You have no knowledge of it; correct?
A. No, I don't.
Q. Now, I assume what you read, in particular, was the provision regarding screening for bladder cancer; correct?
A. That's correct.
Q. And we're not going to spend a lot of time on it, but I just want to refer to you that portion on page 121 -- and this is a copy of what was provided us by your attorneys -- and that's the --
MR. WATTLEWORTH: Do you want him to

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read it or do you want him to -- are you going to ask him about a particular portion?
MR. LEGER: Yeah, I'm just going to ask to the --
BY MR. LEGER:
Q. Do you disagree with the recommendations under the recommendations in the recommendations square?
A. Yes.
Q. I'm sorry. Yes, you agree?
A. I agree with the recommendations.
Q. In connection with your opinion, were you given any internal company documents to review by any of the tobacco companies --
A. No.
Q. -- or regarding any of the tobacco companies?
A. No.
Q. You're a subscriber to the Journal of the American Medical Association?
A. I am.
Q. Have you followed articles or publications in JAMA regarding the public disclosure of documents in the Minnesota trial and documents regarding Brown & Williamson?

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A. No.
Q. Would you be interested in seeing any of those documents?
A. If I'm told that they're particularly interesting or relevant.
Q. By whom?
A. It depends.
Q. How about if I tell you they are?
A. They'd be worth a read.
Q. Okay. Have -- in connection with your working in the Engles case, after your deposition, were you requested to do any additional research or study before testifying at trial?
A. Was I requested?
Q. Yes, sir.
A. I don't think I need to be requested.
Q. Did you do additional research after your deposition?
A. Yes.
Q. Okay. In what regard?
A. Just general information about bladder cancer and --
Q. Do you expect to do any additional research or study in preparation for testimony at

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this trial, in the Scott case, than what you've done already?
A. If something new comes across my desk, yes, I certainly will. In my general reading of the literature, absolutely.
Q. In the context of what we've discussed today, has anything that we've talked about today suggested that you may want to do additional research?
A. I wouldn't say -- I couldn't say specifically on what, but, yes, in general, you know, one keeps up with the literature anyway, and now that my interest is piqued by this, I certainly will. I mean, something comes up on bladder tumor or antigens or something, I -- my interest is going to be clearly brought to that.
Q. Okay. But, in particular, nothing that we've talked about today has suggested to you that you want to look in any particular subject matter in the context of your testimony; correct?
A. No.
Q. In Florida, when a medical malpractice case is filed, is it filed in court or is there some type of administrative procedure?
A. It has to go through a panel of

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doctors first, yes.
Q. Now, did -- in the case of the three malpractice cases in which you were a defendant, did they go beyond the panel of doctors?
A. Yes.
Q. And so they were filed in court?
A. Yes, they were.
Q. And so they would be public record?
A. They are.
Q. What county would they have been filed in?
A. Hillsborough.
Q. All three of them?
A. Yes.
Q. Are you aware of the fact that the jury in the Engles case found that smoking causes bladder cancer?
A. Yes.
Q. Did you testify only regarding bladder cancer?
A. I did.
Q. Did you disagree with that verdict?
A. They're not scientists. They're not physicians. For -- in the way that they interpreted, I guess, you know, I go along with

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them, but as a physician, I know -- and as a semi-scientist -- that that actual causation factor has not been -- is not satis -- not brought to my satisfaction that I would accept it and say that smoking definitely causes cancer in and of itself.
Q. And I know -- and I'm not going to quibble with you -- you and the lawyer quibbled over the term "reasonable medical certainty." Is reasonable medical certainty any different to you than reasonable medical probability?
A. Well, they are two different words, probability and certainty --
Q. Mm-hmm.
A. -- so they're not equivalent.
Q. Okay. Would you have an opinion as to a reasonable medical probability as to whether or not cigarette smoking causes bladder cancer?
A. As I said about that at that time, and I will say now and in the future, there are multiple causes for cancer, and at present we accept that there is a -- what we call a two-hit theory in that you start out with some genetic predisposition for it, and then some environmental exposure causes the expression of that susceptibility so that one thing by itself, no,

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doesn't cause cancer.
Q. Okay. You would agree that cigarette smoking is a contributing cause to cancer --
A. It's clearly --
Q. -- in the bladder, correct?
A. -- true, yes.
Q. Would you also agree that cigarette smoking can contribute to the development of bladder cancer?
A. Very possibly, yes.
Q. Have you, in the past, participated in any type of a focus group or a mock trial or anything of that nature in connection with your testimony in either the Engles case or this case?
A. No.
Q. Have you been told that you may participate in such an activity?
A. No, I haven't.
MR. LEGER: I keep trying to think of something else. I feel guilty. I think we can conclude the deposition at this point.
MS. DESUE: You -- the only other thing is whether you would want to offer the rest -- the rest of his file was basically reports

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from various experts, review of Dr. Wiener's deposition testimony --
MR. LEGER: Oh, right.
MS. DESUE: -- if you wanted to offer any of those.
MR. LEGER: Well, yeah. Let me spend a couple minutes with you on that.
BY MR. LEGER:
Q. Dr. Sartor's report, is there any fundamentally that you disagree with in the context of Dr. Sartor's report?
A. This isn't Dr. Sartor's report, is it?
Q. No.
MR. WATTLEWORTH: Do you have a copy of that?
MR. LEGER: Let's pull it out.
MS. DESUE: I think it's attached. Yeah. Let me just get for you. There we go.
BY MR. LEGER:
Q. And I'm going to turn it to the page that -- page 5 -- that refers to bladder cancer in particular.
A. Okay.
MR. WATTLEWORTH: So your question

is, is there anything that he disagrees with?
MR. LEGER: Yes.
MR. WATTLEWORTH: So, I mean, he -- do you want to go ahead and read --
THE DEPONENT: Okay.
MR. WATTLEWORTH: -- down through that again, if you need to.
MS. DESUE: I mean, it's all part of the record anyway.
THE DEPONENT: No, I don't have any problem with that.
BY MR. LEGER:
Q. Okay. Thank you. Have you seen reports from Dr. Schoenberg and --
A. I have.
Q. -- Dr. Ebbert?
A. I have.
Q. Anything you -- that you observed that you disagree with in their reports?
A. Again, I'd have to review them.
Q. I'll give you both of those.
MR. WATTLEWORTH: Are you going to ask him to review Schoenberg's entire report right now?
MR. LEGER: Yeah. And if you want

to take a break --
MR. WATTLEWORTH: It's like 10 or 15 pages long. That's why I asked. Actually, let's go off the record for a second.
MR. LEGER: Let's go off the record.
(Discussion off the record.)
BY MR. LEGER:
Q. And just for the record, while we were off, counsel for the defendant reminded you that these reports are expert reports that were prepared in this litigation on behalf of the defendants, and then you reviewed them off --
A. I have.
Q. -- off the record? Anything significantly that you disagree with in these reports?
A. No.
MR. WATTLEWORTH: If I could just let the record reflect that he took a fairly brief opportunity to review them, and Dr. Schoenberg's report is 10 to 15 pages and it's -- you know, the minutiae of which he didn't have an opportunity to refresh his recollection.
MR. LEGER: I would agree; he really

skimmed the reports.
BY MR. LEGER:
Q. But in any event, your recollection is that you did, at one point, study them a little bit closer than you just did?
A. I did.
Q. And there was no significant disagreement that you had with those reports?
A. That's correct.
MR. LEGER: I have no further questions.
THE DEPONENT: Okay.
MR. LEGER: Thank you, Doctor.
THE DEPONENT: You're welcome.
MR. WATTLEWORTH: If we could just have a couple of minutes to look over my notes and --
MR. LEGER: Sure.
MR. WATTLEWORTH: -- confer.
(Discussion off the record.)
CROSS-EXAMINATION BY MR. WATTLEWORTH:
Q. Dr. Cockburn, I have just a couple of follow-up questions I'd like to ask you. Counsel for the plaintiff, a moment ago, asked you to look at Dr. Sartor's report, very briefly --

A. Yes.
Q. -- and asked you if there was anything in that report with which you disagreed. And just to make sure everything's clear on this issue, you are aware that Dr. Sartor is advocating, along with the other experts for the plaintiffs, that a population of smokers in Louisiana are the ones who are going to be screened for bladder cancer? In other words --
A. That's correct.
Q. -- they will be screened because they are smokers or ex-smokers. Is that your understanding of what their --
A. Yes.
Q. -- approach is?
A. Yeah.
Q. Okay. Now, do you agree with that proposal?
A. No, no, and I said so before. Not just because they're smokers. I mean, I thought I made that point clear, and I didn't pick that up again in Dr. Sartor's report. Again, not just because they're smokers, but if they had hematuria. And hematuria is the defining trigger that will then alert the clinician to go and do the

other necessary workup.

I don't think that people should be screened in the way that we've been talking about screening just because they're smokers. The yield on that is much, much, much too low to -- it's certainly not cost effective -- to justify it.

Q. And we -- you discussed this a little bit earlier, but, again, I want to make sure this is clear, because I'm not sure it was. Is it your opinion that the urinalysis itself is the initial screening tool?

A. Is the screening tool.

Q. Is the screening tool.

A. Yes.

Q. Okay.

A. And when we're talking about screening, that's what the urinalysis does, is to screen for those individuals who might be susceptible to developing some other abnormality, and cancer is one of them. But I accept that as a screening tool. None of the others have the lack of expense, ease of facility of use, and wide applicability as urinalysis.

Q. And after urinalysis, if the person who is screened has -- is positive for hematuria,

blood in the urine, at that point, the other tests that you would prescribe for that patient -- cytology, cystoscopy, IVP -- those are follow-up tests --

A. Those are follow-up tests --

Q. -- to determine --

A. -- and they're not screening tests.

Q. And you don't -- and that procedure of beginning with a urinalysis and then follow-up, depending on what you find -- in other words, if you find hematuria, then you follow up --

A. Right.

Q. -- with those three methods -- those are, again, not dependent on whether you're a smoker --

A. No.

Q. -- or an ex-smoker --

A. That's correct.

Q. -- or a never smoker?

A. That's correct.

Q. I think you stated earlier, it's something that -- urinalysis is something that you should have on a yearly basis as part of your --

A. If you've never been a smoker and you have blood in your urine, you get the same

workup.

Q. Okay. We talked earlier -- counsel for the plaintiff asked you a lot of questions about NMP-22 as an adjunct to cytology, cystoscopy. Is there any kind of a consensus in the medical community as to the appropriateness of using NMP-22 as an adjunct?

A. Yes. I think the consensus now is that it is not of value to be used in this context. It has potential, as do several other tests, but the variability in its detection ability in terms of its sensitivity, in terms of its specificity, are too broad to recommend it to be used in this fashion.

As I mentioned before, the most -- the best way that it can be used right now is for those individuals who have been found to have bladder cancer and have been treated, and now you're treating them for follow-up and you want to decide whether or not I want to do a cystoscopy on this individual in follow-up for recurrence of their cancer. That's when the NMP seems to have better validity in its use. But as an open-ended screening-type test, it's far, far too insensitive to be used in that context at this time.

Q. Is it accurate to say, then, that in the urologic community, it is not the standard of care --

A. No.

Q. -- to utilize NMP-22 as a follow-up device when you've got hematuria in the blood --

A. It's --

Q. -- following the urinalysis?

A. It's not the standard of care for follow-up for hematuria or for bladder cancer. It's not the -- it's presently being studied as such, but it's not the standard of care to be used at all, in any context, whether just hematuria or if a patient has defined history of bladder cancer.

It's one of those new things that has come along, and it's under evaluation. And possibly within the next five years, we're going to know more about it or it'll be refined better so that we can -- it will have greater utility, but right now, it doesn't.

MR. WATTLEWORTH: That's all we've got.

MR. LEGER: Okay. Doctor, I've got a few more questions.

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REDIRECT EXAMINATION BY MR. LEGER:
Q. Doctor, you provided us with a number of medical articles --
A. Yes, sir.
Q. -- and which you indicated you had relied upon in the context of your opinions; correct?
A. Correct.
Q. And a number of those reported testing of a number of the diagnostic tools or monitoring tools or screening tools or tests that you spoke about on the second page of your report; correct?
A. That's correct.
Q. And those included vascular endothelial growth, P53, BAT Stat (sic), Telomerase, NMP 22, and the others that you'd suggested; correct?
A. That's correct.
Q. Would you agree that, largely, this literature is supportive of the usefulness of those tools in detecting bladder cancer?
A. No.
MR. WATTLEWORTH: Are you talking about all those tools?

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MR. LEGER: Yes.
MR. WATTLEWORTH: Okay.
A. No, no, no. I think what the articles say is that there is an ongoing search for something that would be better than cytology. At the present time, there is none. None are better than cytology. If you take cytology and you compare it against each one of those individually, the cytology is still a better test.
BY MR. LEGER:
Q. Now, you earlier testified that if you take NMP-22 and cytology together --
A. Yes.
Q. -- they both complement each other; correct?
A. You have an adjunctive benefit; you have more information.
Q. So you would agree, of course, in the context of attempting to diagnose bladder cancer, if you did NMP-22 and cytology together, you have a better predictive potential than using cytology alone; correct?
A. For people who have already had cancer of the bladder.
Q. What about people who have

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hematuria?
A. No.
Q. You don't think that it predicts bladder cancer --
A. No.
Q. -- in people with hematuria?
A. No.
Q. All right. Now, you will recall that my earlier hypothetical had nothing to do with people that already have bladder cancer; correct?
A. No, then I don't recall that.
Q. Okay. The record will speak for itself.
So you also agree, Doctor, that screening is recommended in people who are high risk to exposure to environmental carcinogens; correct?
A. That's correct.
Q. And the screening you would suggest -- the initial lining of screening -- would be urinalysis; correct?
A. That's correct.
Q. And once screened for hematuria, and a finding of hematuria, there are secondary screening opportunities that you have; correct --

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MR. WATTLEWORTH: Object to the form.
Q. -- including the use of the cytology?
MR. WATTLEWORTH: Object to the form.
A. Well, it's no longer called screening at that point.
BY MR. LEGER:
Q. What is it called at that point?
A. That's called a workup.
Q. Okay. And what is a workup?
A. A workup is where you have a defined abnormality and now you're looking for the cause of that abnormality.
Q. Okay.
A. So the abnormality is just blood in the urine.
Q. Okay. So the urinalysis itself is the screen in the population where you haven't defined the abnormality yet; correct?
A. That's correct.
Q. Okay. Now you have found an abnormality --
A. Mm-hmm.

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Q. -- and you're simply trying to -- you're trying to limit and differentiate between what disease or illness may be causing the abnormality; correct?
A. Or none.
Q. Or none, or to exclude --
A. Right.
Q. -- disease or illness; correct?
A. Yeah.
Q. Now, do any of these studies that you show -- that you present with your -- in your reference guide suggest that NMP-22 is not effective in attempting to identify the abnormality in hematuria?
A. None of them speaks to any of them as being ineffective. It's a relative degree of effectiveness in terms of what you want from a screening test. Okay? A screening test, you want high sensitivity to pick out all of the positives in a population, and you want -- and specificity so that all the positives that you pick out are -- have what you're looking for.
In that regard, all of those tests show promise. And most of the articles point out that if you combine two of them, then they approach

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some of the accuracy of cytology. If you combine NMP-22 with the cytokine 33 test, then you have -- you approach it. Now you have two tests, so two of those together may equal the one that you're using now. So what we want is something better than cytology.
Q. So if you -- and as you testified before, if you combine NMP-22 and cytology, you have a modality that's even better than cytology alone; correct?
A. In specific patients, those who have had cancers before that you've treated and you're treating -- you're now looking for recurrence.
Q. Okay. You believe that NMP-22 is not effective in identifying the source of abnormality in persons who did not have cancer already?
A. No, because that test is only looking for cancer cells, and so it is not as effective as we would like it to be.
Q. Okay. And what is the -- or do you know what the positive predictive value of NMP-22 is?
A. Oh, it's all over the place.
Q. Okay. What is the negative

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predictive value of NMP-22?
A. Again, it's very variable. Just because it's negative, it doesn't mean that you don't have a tumor.
Q. Right.
A. And we're --
Q. That's true of many tests; correct?
A. That's true of many tests, but --
Q. Including cytology?
A. That's correct.
Q. And in any event, the articles speak for themselves --
A. That's correct.
Q. -- in the context of what they found?
A. (Deponent nods head.)
Q. The article by Marta Sanchez-Carbayo, Comparative Sensitivity of Urinary -- is it CYRFA 21-1, etc.? -- that's an article provided to you by lawyers for the tobacco companies or is that one you found yourself?
A. What's the journal?
Q. It's from --
A. Is that Journal of Urology?
Q. That is Journal of Urology.

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A. I think that's one of mine.
Q. What's the relevance of a high negative predictive value?
A. High -- it's a strike against the test. The test is inaccurate in terms of high false negatives.
Q. And how does that relate to sensitivity to detect malignancy?
A. Well, that means that the sensitivity is less than desirable.
Q. Okay. If the sensitivity is a hundred percent for invasive disease, is that good or is that bad?
A. That's good for invasive disease.
Q. And if it's 70 percent overall, what does that mean?
A. That means that it's very good for invasive disease, very poor for early stage disease.
Q. For superficial tumor --
A. Or --
Q. -- or early stage invasive disease?
A. Or early stage invasive disease.
Q. Doctor, would you agree that painless hematuria occurs in about 85 percent of

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patients with bladder cancer?
A. Yes, I would accept that.
Q. Would you also agree that nearly all patients with bladder cancer have at least microhematuria?
A. Yes, sir.
Q. How much does a urinalysis cost?
A. Medicare will pay you $6 for it sometimes.
Q. Will Medicare pay for cytology?
A. Yes.
Q. What will they pay?
A. I don't know. I don't know how much of it they will pay. I really don't know.
Q. About how much does cytology cost?
A. It's about $120.
Q. Would $40 be a good price for cytology?
MR. WATTLEWORTH: Object to the form. Are you talking about Medicare reimbursement?
MR. LEGER: I'm talking about cost.
MR. WATTLEWORTH: Oh.
MR. LEGER: Simply cost.
MR. WATTLEWORTH: Oh, if it cost

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$40?
MR. LEGER: Mm-hmm.
THE DEPONENT: With the same degree of accuracy?
BY MR. LEGER:
Q. Is there different types of cytology?
A. Different types of people who are reading it, and that's what you're depending on.
Q. Okay.
A. And so, you know, if you're going to pay someone cheaply, you might not get the best person there, so --
Q. Presumably, you can get volume discounts for tests; right?
A. Presumably.
Q. You would agree, even in medicine?
A. Yeah, well, I think the $120 is probably the volume discount.
Q. Okay. But if you could get it for $40, that would be pretty cost effective; right?
A. Yeah.
Q. Assuming everything else?
A. See, I'm --
Q. Assuming competency and otherwise?

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A. I shouldn't make a statement about this, because I'm totally in the dark as to what the costs of cytology are across the board. Some places -- I'm sure there are places that you can get it for less than $120, so I don't know. $60, $80. I don't know.
Q. You would agree that the reason that cytology is not -- or one of the reasons that cytology is not recommended for screening or monitoring is the high cost; correct?
A. We use it for monitoring, but we don't use it for screening.
Q. What's the difference? I guess that's what we need to talk -- what's the difference between monitoring and screening?
A. Okay. When you have an unknown population that you're surveying, that's screening.
Q. Okay.
A. When you have a known population that has the disease, then you're monitoring them for the disease recurrence.
Q. What about a population that has a high risk for the disease?
A. You're screening.
Q. Okay. So you consider that you're

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not monitoring until you've already found some evidence of the disease?
A. That's correct.
Q. Okay. Well, is there -- is that a definition that's accepted in the scientific literature?
A. I would think so.
Q. Is it -- would you agree that the terms "screening" and "monitoring" are used oftentimes --
A. Interchangeably?
Q. -- interchangeably?
A. I think inaccurately so, yes.
Q. Okay. But you would agree, generally in the medical profession, it may be often used interchangeably -- the two terms?
A. I don't think by doctors, by clinicians.
Q. Okay. Where can we find the definition of those two terms?
A. I don't think you're going to get a hard-and-fast one. You know, you monitor someone for their heart disease, you monitor their hypertension, but if you have an asymptomatic population, you're not monitoring it; you're

basically just checking to see if they have hypertension.

Q. Have the lawyers for the tobacco companies shown you the legal definition of medical monitoring --

A. No.

Q. -- under Louisiana law?

A. No.

Q. I would like -- I'm going to show you that, and I want -- I mean --

MR. WATTLEWORTH: You're talking about the Bourgeouis case?

MR. LEGER: The Bourgeouis case.

MR. WATTLEWORTH: Yeah, that outlines the factors for recovery of medical monitoring?

MR. LEGER: Right.

BY MR. LEGER:

Q. Have you seen the factors in the Bourgeouis case in Louisiana?

A. I don't know the Bourgeouis case. I don't know if I did.

MR. WATTLEWORTH: Let's go off the record for a second.

(Discussion off the record.)

BY MR. LEGER:

Q. Doctor, off the record, we discussed -- you have been shown -- Counsel has indicated that you have been shown the factors, without identifying, apparently, to you the name of the case --

A. Yes.

Q. -- that we consider make up the law of medical monitoring in the state of Louisiana; is that correct?

A. Yes, sir.

Q. In what way were you shown that?

A. Well, I have to tell you, I don't even remember the context in which I was shown it, so --

Q. Were you given a piece of paper?

A. You're identifying something that I can't place at all in my memory, because you keep mentioning the Bourgeouis case, and I don't know it as such. If it was shown to me as the Louisiana medical monitoring statute or whatever, then perhaps I was -- I had seen it, but I don't remember it.

Q. So that we're very clear, I'm -- I am not trying to suggest what you have been shown;

I'm trying to find out what you have been shown or told --

A. I haven't seen it to --

Q. -- by lawyers.

A. -- to refresh my memory. I don't know.

Q. Were you given a piece of paper with something on it that you were told, This is medical monitoring in Louisiana, or were you told it orally?

A. I was given quite a bit of information from Sartor, Weiner, Schoenberg, as well as the literature excerpts, but I don't remember this one as such.

Q. Okay. I mean, you've basically given us -- if they showed you something that was medical monitoring, they took it back?

A. If you let me see it, I might be able to remember.

Q. Okay. Well, you obviously -- I promise you, you weren't given this.

A. Okay.

Q. This is mine.

A. This is an excerpt from the --

Q. This is an excerpt --

A. -- statute?

Q. This is an excerpt from the case.

A. Case.

Q. From the case, yeah, in Louisiana that I have prepared for my purposes in very large print that I can even read without my little glasses. But what I'm trying to find out first, before we even get to this, is, what was shown to you or told to you the law is?

A. I don't recollect.

Q. Okay. Let me ask you this: Would you agree that the program recommended by the doctors and scholars in Louisiana for medical monitoring with respect to bladder cancer -- and that is urinalysis for hematuria, then NMP-22 and cytology -- is different from that normally recommended in absence of exposure to toxic chemicals?

A. It is different, yes.

Q. Okay. You have no reason to believe that the doctors that put this together in Louisiana and elsewhere were not qualified physicians, do you?

A. No.

Q. Okay. You also agree that

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procedures exist that make the early detection of bladder cancer possible; correct?
A. Yes.
Q. You also agree that cigarette smoking presents a significant exposure to carcinogens found in cigarette smoke; correct?
MR. WATTLEWORTH: Object to the form.
A. Given the volume and duration.
BY MR. LEGER:
Q. Okay. You agree that cigarette smoking -- it's common, unequivocal medical and scientific opinion that cigarette smoke contains a large number of known carcinogens in humans; is that correct?
MR. WATTLEWORTH: Object to the form. Argumentative.
A. That cigarette smoke contains -- yes -- carcinogens, yes.
BY MR. LEGER:
Q. And those carcinogens are in particulate form; correct?
A. Yes.
Q. You would agree that a person who smokes cigarettes is at an increased risk of

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contracting bladder cancer and other serious diseases over a person who has never smoked cigarettes; correct?
MR. WATTLEWORTH: Object to the form. Vague.
A. Depending on the number of cigarettes per day per year.
BY MR. LEGER:
Q. How many cigarettes per day? How many years?
A. It would seem to me, from what I've read, over 15 cigarettes a day for an extended period of years.
Q. How many?
A. Without -- I would say it would have to be over ten years.
Q. Okay. And where do you get that figure from?
A. I picked it out of my head, based on generalizations that I'd seen before for exposure to tobacco.
Q. Okay. That's opposed to five pack years of cigarettes? Are you familiar with the term "pack years"?
A. A pack a day for five years, yeah.

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Q. So you don't agree or believe that five pack years of cigarettes is significant exposure; correct?
A. Significant for the development of bladder cancer?
Q. Yes, sir.
A. It depends on the susceptibility of the individual.
Q. Okay. And we're talking about individuals in total. We don't know susceptibility, do we?
A. No, we don't.
Q. All we know is that approximately 50 percent of bladder cancers have been related to smoking cigarettes; correct?
MR. WATTLEWORTH: Object to the form.
A. I don't like generalizations like that because it's one factor in an individual's total exposure in his daily life. Is that individual also a truck driver? Does he also work in an industry in which there are other carcinogens? It's hard to say.
BY MR. LEGER:
Q. Are you asking me?

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A. Well, I'm saying that that's why that figure is inaccurate.
Q. Are you questioning the scientific literature?
A. I'm questioning the interpretation of the scientific literature when based only on one factor.
Q. Including Campbell's Urology; correct?
A. When based on only one factor, yes, absolutely.
Q. But you would agree -- and I'm not asking you to base it only on one factor; I'm asking you to consider that the epidemiological data and the conventional scientific thought suggests that cigarette smoking is a factor -- a risk factor in 50 percent of bladder cancers.
MR. WATTLEWORTH: Object to the form.
BY MR. LEGER:
Q. Would you agree with that?
A. Fifty percent of bladder cancers in this country?
Q. Yes, sir, in the United States of America.

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A. No --
Q. You disagree with that?
A. -- no. Absolutely, because they're -- when you include 50 -- when you say 50 percent of cancers, you're including superficial cancers as well as invasive cancers, and it would seem to me that superficial cancers are not clearly identified -- well, I don't even know that. I can't even say that.
Q. Right. And I'm not saying anything. I'm just asking you if, one, you agree that there is a body of scientific thought that suggests that cigarette smoking is a substantial risk factor in 50 percent of bladder cancers.
A. In a substantial amount of bladder cancers, yes.
Q. Okay. Would you agree that a cigarette smoker's risk of contracting bladder cancer is greater than the risk of contracting bladder cancer had he not smoked?
A. Yes.
Q. Would you also agree that the risk of a cigarette smoker in contracting a serious disease, such as bladder cancer, is greater than the chance of the members of the public at large of

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developing a disease, including nonsmokers?
MR. WATTLEWORTH: Object to the form.
A. Yes.
BY MR. LEGER:
Q. Would you agree that there is a demonstrated clinical value in the early detection of bladder cancer?
A. Yes.
MR. LEGER: I don't have any further questions.
MS. WIMBERLY: Just one minute, Walter.
MR. LEGER: Well, actually, I do.
BY MR. LEGER:
Q. I just want to -- just one question, and the question is yes or no. Is -- I'm showing you a document, which I have produced, which I believe is a summary of the factors of Bourgeouis, and which I think counsel has agreed basically is word for word out of the -- for what it is, and just ask you if you have seen a document which outlines those factors in identical wording.
A. I may have. I don't remember.
Q. You've seen a document that is

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similar in wording to that document?
A. I can't say that I remember exactly, as such.
Q. Okay. Do you recall being told that these are basically the factors of medical monitoring in Louisiana?
A. No.
Q. Okay. Just one other thing. You talked about, both in your deposition and your trial testimony in Engles, and to some very limited degree here, that there are a couple of steps in the development -- a couple or a few steps in the development of bladder cancer; correct?
A. Okay, yes.
Q. One of those steps requires or involves an impact of a carcinogenic substance with the cells of the bladder; is that correct?
A. That's correct.
Q. And is it -- would you agree that it is the general agreement in the scientific community regarding bladder cancer that the impact of the carcinogen on the epithelium of the bladder is a significant event in the development of bladder cancer?
MR. WATTLEWORTH: Object to the

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form.
BY MR. LEGER:
Q. Assuming that you eventually find bladder cancer.
A. Yes.
Q. I understand carcinogens can impact the epithelium and never get -- you never get bladder cancer; right?
A. That's correct.
Q. Assuming there is -- you say that there has to be some earlier event to the development of the carcinogen in order for bladder cancer to develop; right?
A. That's correct.
Q. Something else had to have happened first, maybe a genetic predisposition, some other impact or insult or trauma; correct?
A. Right; that's correct.
Q. And then eventually a carcinogen impacts the walls of the epithelium; correct?
A. That's correct.
Q. And then there may be other events or factors, but -- and then you end up with bladder cancer; correct?
A. That's correct.

MR. LEGER: No further questions.
MS. WIMBERLY: One minute, Walter.
THE VIDEOGRAPHER: Do you want to go off the record?
MR. WATTLEWORTH: Just for a second, yes.
(Discussion off the record.)
MR. WATTLEWORTH: We have no further questions, but I would like to reserve the right for him to read and sign his deposition.
MR. LEGER: Oh, absolutely.

(Deposition adjourned at 1:05 p.m.)

JURAT

I, ALDEN G. COCKBURN, M.D., do hereby certify that I have read the foregoing transcript of my testimony, taken on October 26, 2000, and have signed it subject to the following changes:

PAGE LINE CORRECTION

DATE:

Sworn and subscribed to before me on this day of

NOTARY PUBLIC

CERTIFICATE

I, Cynthia L. Varney, a Shorthand Reporter and Notary Public of the State of Florida, do hereby certify that prior to the commencement of the examination, the witness was sworn by me to testify the truth, the whole truth, and nothing but the truth.

I do further certify that the foregoing is a true and accurate transcript of the testimony as taken stenographically by and before me at the time, place, and on the date hereinbefore set forth.

I do further certify that I am neither of counsel nor attorney for any party in this action and that I am not interested in the event nor outcome of this litigation.

Notary Public of the State of Florida

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